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ABSTRACT

This guide, in two sections, emphasizes a community-based, school-focused collaborative approach to preventing youth suicide in Wisconsin. Cooperative school district and community agency endeavors frame the approach. The following three-part philosophy undergirds it: First, youth suicide is a community problem requiring a community solution best handled by joint school-community efforts. Second, youth suicide derives from teenager hopelessness. Third, youth suicide prevention efforts can be effectively established using existing service delivery systems. The first section defines the problem, explains program principles, describes how to plan and implement prevention programs, and clarifies the postprevention process in the aftermath of a suicide. The second section describes model suicide prevention programs around the state. (JAM)

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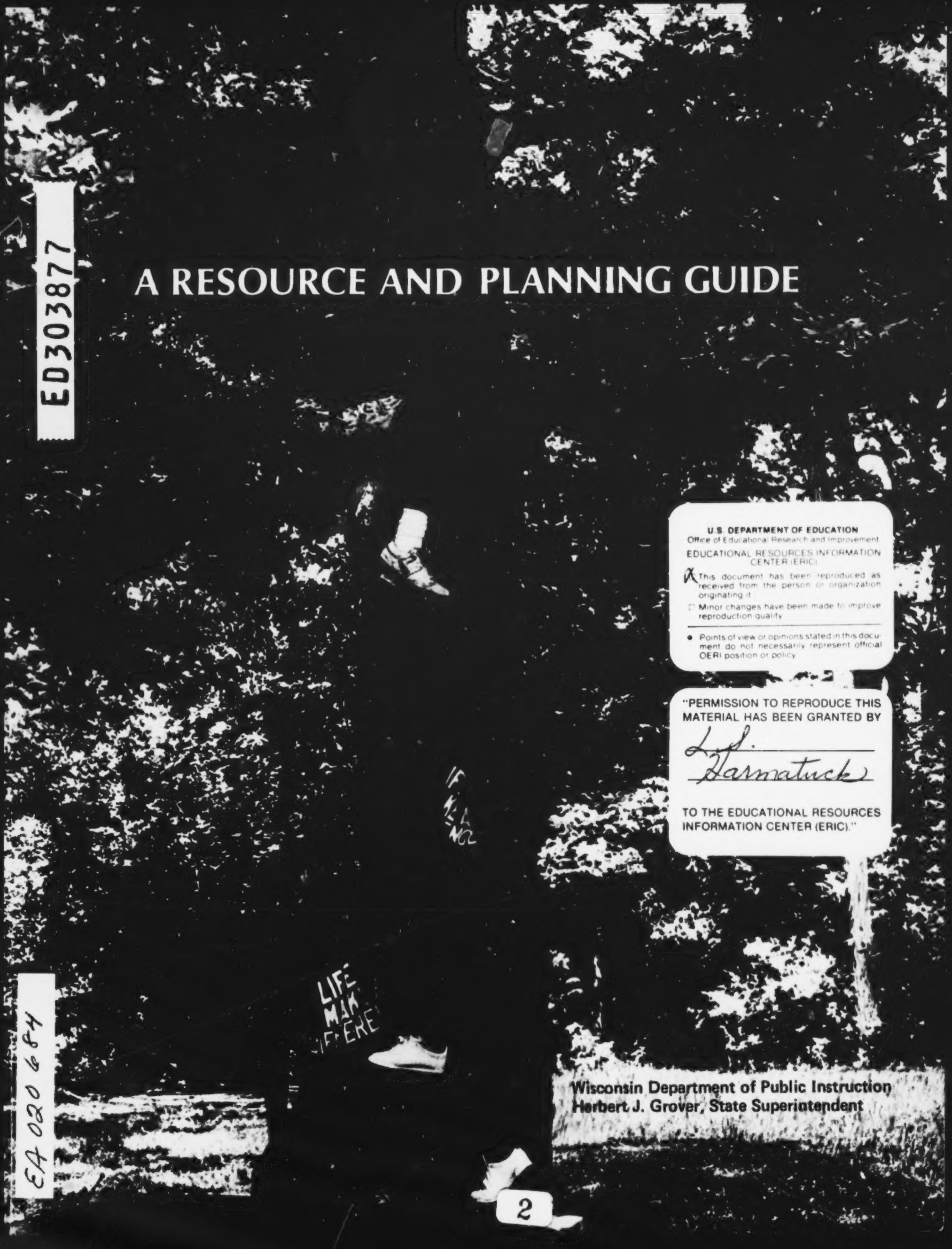

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Suicide Prevention:

A Resource and Planning Guide

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Foreword

I appreciate the opportunity to share with you my personal concern regarding a very serious problem that has developed in our state as well as across the nation. It is the problem of an increasing suicide rate among our youth. The statistics are alarming, but we can do something about it, and this guide provides a good starting point.

In 1985, State Representative Margaret Krusick of Milwaukee introduced a legislative proposal aimed at fostering state, regional, and local collaboration between schools and community agencies to confront and deal with the increase of suicide among adolescents. The efforts behind this legislative initiative were successful, and Wisconsin became one of the first states in the nation to enact, as public-school policy, school-based adolescent suicide prevention programs.

While Representative Krusick's legislation was being considered, Department of Public Instruction staff were working with their counterparts in the Department of Health and Social Service (DHSS) to develop ways to help school districts and communities better meet the needs of troubled youth in a variety of areas. This program guide is one outcome of that collaboration with DHSS, and is intended to help school districts and local communities establish local suicide prevention programs.

You have my support and best wishes for your efforts in this important undertaking.

Herbert J Grover

Herbert J. Grover
State Superintendent

Preface

When I first became aware of the youth suicide problem in our state, I felt something needed to be done as quickly as possible. The 1985 legislature responded by supporting the youth suicide prevention bill I introduced. The bill supports a coordinated effort by state and local agencies to develop effective prevention programs.

The collaborative efforts of the State Department of Public Instruction and the State Department of Health and Social Services have given direction and leadership to our state's youth suicide prevention effort. The response of local districts and community agencies has been excellent. My congratulations and thanks go out to all of you at state, county, district, and community levels who are laboring so diligently for the benefit of our children.

As a state legislator and as the chairperson of State Superintendent Herbert J. Grover's Advisory Council on Youth Suicide, I look forward to our continued progress in solving this problem.

Margaret Ann Krusick

The Honorable Margaret Ann Krusick
State Representative

Acknowledgments

This guide is the product of the efforts of many people. While it would be impossible to thank everyone, some must be singled out for recognition. These people have made this guide a more useful document for field staff, and their critiques have substantially enhanced its content and format.

Mary Conroy, prevention specialist with the Wisconsin Department of Health and Social Services, was instrumental in organizing and presenting this material to over 2,000 people at workshops throughout Wisconsin. Her efforts have been central to translating into reality the idea of collaboration among the social services, mental health, and educational systems.

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Introduction 1

Overview to the Wisconsin Approach

This guide emphasizes a community-based, school-focused approach to preventing youth suicide. Working together, school districts and community agencies can develop collaborative programs. The approach is based on a belief in a three-part philosophy.

- Youth suicide is a community problem requiring a community solution. For that reason, youth suicide prevention is best served if it is done on the basis of a *community-based, school-focused* approach. Community agencies and schools working together have access to youth, understands youth issues, and possess the means for prevention and treatment. This approach maximizes resources and is more cost effective than schools and community agencies operating separately.
- Youth suicide is the end result of a number of problems which produce a state of hopelessness. A coordinated *youth issues* plan which deals with such problems as teen pregnancy, delinquency, child abuse, child sexual abuse, alcohol and other drug abuse, and the effect of divorce and poverty on youth self-esteem is needed to reduce the youth suicide rate.
- Youth suicide prevention efforts can be effectively established by *using existing service delivery systems.* Although there are differences in quality and quantity, many prevention and intervention resources already exist in each community. School student assistance programs, school pupil services staff, county departments of social services, 51.42 boards, crisis hotlines, private agencies, parent-teacher organizations, and volunteers are all legitimate and effective existing resources that can be marshalled to combat youth suicide.

This three-part philosophy can help to reduce the youth suicide rate and can become the basis of a comprehensive community effort to effectively deal with youth issues in a collaborative manner.

Basic Facts About Youth Suicide

Youth suicide statistics indicate a serious problem. Suicide is the third-ranked cause of death for students between the ages of 15 and 19. Childhood depression, previously an almost unrecognized phenomenon, is becoming increasingly identified in young children. Early intervention with children who are depressed frequently prevents the problem from becoming entrenched in later life.

The following suicide facts were gathered from a number of studies and reports which are listed in the references at the end of this section.

- One study of teen suicide found that 60 percent of all high school seniors have **seriously** considered suicide by the time they graduate.

- More males than females die by suicide, but three to five times as many females attempt suicide.
- Most frequent causes of male suicide deaths are shooting and hanging, while females more often use poison to attempt suicide.
- Most experts agree that suicides and attempted suicides are underreported. Reasons for this include the following.
  - —Many one-car accidents are thought to be suicides, but local coroners use "accidental death" to spare the families' feelings.
  - —The social stigma associated with suicide or attempted suicide encourages families and professionals to avoid admitting the truth.
  - —Reporting procedures are neither uniform nor effective.
- People who talk about suicide do act on their feelings. Seventy-five to 80 percent of the people who die by suicide have told someone of their intention. Talking about killing themselves is a way to ask for help.
- Those who attempt suicide but survive do attempt again. Commonly, someone who dies by suicide has attempted suicide in the past. Unless life changes for attempters, suicide remains an option for them.
- Any attempt, even an apparently nonlethal one, should be seen as a cry for help which must be responded to to prevent a future death by suicide.
- Death by suicide is accompanied by a note only about one in three times.
- Most people who die by suicide really want to live. They choose places for their act where they are likely to be found and rescued.
- Talking about suicide reduces the chance of its occurring. Where the facts of suicide have been faced and help made available, the youth suicide rate has gone down.
- The condition of depression, which is associated with youth suicide, will get worse with time unless the youth is given help.
- People who die by suicide are not mentally ill. They may be depressed, but the suicidal crisis is only 24 to 48 hours long. If help is initiated during that time, the individual can learn how to successfully cope with the causal problems.
- While it is difficult to establish an exact number of suicides in the age group 0-18, literature shows that nearly 5,000 teens die by suicide each year. This means 13 to 14 adolescents die by suicide in the United States every day.

The Suicidal Personality

Suicide is a preventable death. The signs of a suicidal youth are observable most of the time, and the actions necessary to help them are well documented.

People who are suicidal present a picture of being without hope, helpless to change the things in their lives which hurt them. These people feel their current unhappiness will not change to happiness. Suicidal people are afraid of failing and feel guilt over past or present failure. They expect to fail now and in the future. They would like to control or punish others, and they see suicide as the one action in their lives they can control. They hope to bring attention or love to themselves through this act. Suicide is not just a way of death. It is a way to end the unhappiness of life.

Youth Suicides in Wisconsin

Department of Public Instruction Survey

In 1985, the Wisconsin Department of Public Instruction (DPI) asked local school districts to report known attempted suicides and deaths by suicide in the last three years. (See Table 1.) The results parallel national trends. More than 1,100 Wisconsin elementary and secondary students attempted suicide during the 1984-85 school year. Forty-nine students actually died by suicide during that same time period. These results are based on reports from 344 of the 432 school districts in the state. Over the past three school years Wisconsin has experienced an average of 39 suicides and 818 attempted suicides each year as reported in this survey.

From 1982-83 to 1983-84, the number of suicides declined, but from 1983-84 to 1984-85, the number rose from 29 to 49. There was a steady rise in attempted suicides each school year covered by the study. The survey showed a 38.5 percent increase in attempts between 1982-83 and 1983-84, and a 45.4 percent increase between 1983-84 and 1984-85.

Only ten percent of the 344 responding districts reported that some kind of suicide prevention effort was underway. Even fewer, 3.5 percent, had a formal policy to assist their staff in dealing with identified suicidal students. Seven major conclusions were drawn from the survey.

- Wisconsin, like other states, has a serious youth suicide problem.
- School districts are responding in a number of ways. They are creatively using relatively scarce fiscal resources.
- Coordination between school districts and community agencies to address the youth suicide problem needs further development.
- Educators are greatly concerned for the well-being of their students.
- Suicide prevention inservice training is needed.
- Youth suicide prevention efforts need to be coordinated with other programs that address youth issues, both physical and psychological.
- Model programs, policies, and curriculums need to be developed and distributed to school districts.

The survey showed that school districts are making efforts to work with community agencies on this problem. Of the 344 responding districts, 306 had made some kind of contact with these resources. The county departments of social services and mental health agencies were the most-used local agencies.

Department of Health and Social Services Report

The Wisconsin Department of Health and Social Services (DHSS) compiles an annual report, "Suicides in Wisconsin," which is a supplement to its accident report. Results from the latest report largely agree with the DPI's 1985 School-Age Suicide Survey. (See Table 2.) DHSS figures show that an average of 57 youths died by suicide each year from 1981-1983. The difference in the two figures, 57 as opposed to 39, can be attributed to several factors. First, the DPI School-Age Suicide Survey reports for a period of 38 weeks rather than 52. Second, the Health and Social Services report is based on coroners' reports while the school study is based on local educators' *perceptions* of the situation. Third, the school data deal with students who are, by and large, 18 or under while the DHSS data include all individuals up to 19 years of age. The two reports do appear to support each other in that they both define a serious problem.

Caution should be exercised in using either of these studies, since both probably reflect a significant *under*reporting of suicides and attempted suicides. Such underreporting is suspected by experts in the field because they believe persons who do the reporting may classify a suicide as accidental death to spare the feelings of family and friends. Underreporting also is linked to the erroneous belief that talking about suicide causes further attempts. The one clear conclusion which can be drawn from the available data is that youth suicide is a serious problem.

Suicide Prevention Legislation

In 1985, the Wisconsin State Legislature enacted suicide prevention legislation (see Appendix H) which contains six provisions, listed below, to encourage a coordinated statewide effort for youth suicide prevention. The law does the following.

- Creates a seven-member Youth Suicide Prevention Council with representatives appointed by the State Department of Public Instruction (DPI), the Department of Health and Social Services (DHSS), and the Wisconsin Council on Criminal Justice. The council advises the State Superintendent on matters pertaining to youth suicide prevention.
- Appropriates $3,000 annually to each of the twelve cooperative educational services agencies (CESAs) to develop youth suicide prevention programs in their service areas.
- Directs the DPI and the DHSS to provide suicide prevention training programs to county social services agencies, mental health boards, and public and private schools.
- Directs the DPI and the DHSS to provide consultation and technical assistance to county social services agencies, mental health boards, and public and private schools.
- Directs school districts to have in place a suicide prevention curriculum by July 1, 1988.

- Protects from civil liability any person who, in good faith, refers a student for being potentially suicidal.

The law sets up a two-faceted approach for dealing with suicide: one facet is developing an awareness of how to recognize and help suicidal individuals, and the other is establishing a suicide prevention curriculum in school districts. Awareness activities involve technical assistance and inservice training from the DPI and the DHSS to public and private schools, county departments of social services, and boards established under ss. 51.42 and 115.365, Wis. Stats. According to the law, the awareness program shall include information on:

- how to assist minors in the positive emotional development which will help prevent suicidal tendencies;
- how youth and adults can detect conditions which indicate suicidal tendencies;
- what action to take when there is reason to believe that a minor has suicidal tendencies or is contemplating suicide;
- how to coordinate school suicide prevention programs and activities with the suicide prevention and intervention programs and activities of other state and local agencies.

The school curriculum must be in place by July 1988 and, as provided in s. 118.01(2)(d)7, Wis. Stats., must emphasize the following:

- skills needed to make sound decisions
- knowledge of the conditions which may cause suicide
- signs of suicidal tendencies
- knowledge of the relationship between youth suicide and the use of alcohol and controlled substances
- knowledge of the available community youth suicide prevention and intervention services
- positive emotional development of pupils

The specific inclusion of both education and health and social services agencies in the legislation is a clear indication of the need for cooperation and collaboration at state, regional, and local levels to reduce youth suicide.

A Prevention Definition

The goal of Wisconsin's suicide prevention legislation is to reduce the rate of youth suicide by educating students, families, school staff, and community agencies on how to recognize and intervene in potentially suicidal situations. Professionals who work in the field recognize primary and secondary categories of prevention. Primary prevention encompasses a variety of activities which help persons engage in tasks which develop positive self-image and coping skills. This involves a combination of efforts designed to encourage individuals to constructively deal with life.

Secondary prevention is the action taken following recognition of the existence of a problem. At times, professionals in the field refer to this as intervention. Alcohol and other drug abuse programs generally fall into the secondary prevention category. Central to these programs are the Student Assistance Programs. Students may refer themselves or peers to the program for evaluation, referral, and support. Suicide prevention programs which concentrate on educating staff, parents, and students to the danger signs of potential youth suicide are also secondary prevention because they respond to an existing problem to prevent a more serious one.

The Wisconsin Prevention Network has developed an excellent definition of prevention.

> *Prevention is a process which promotes health by empowering people with the resources necessary to confront complex, stressful life conditions and by enabling individuals to lead personally satisfying, enriching lives.*

This definition suggests a two-pronged approach to prevention:

- a deliberate and constructive process designed to promote growth of individuals toward their full human potential; and
- the counteraction of harmful circumstances such as health and safety hazards, family stresses, job pressures, isolation, violence, economic hardship and inadequate housing, medical services or child care.

Local Implementation

The roles of prevention, intervention, and treatment must be carefully defined and assigned appropriately to insure adequate delivery of service to youth. The role of the school is to prevent the development of problems through education and a supportive environment. It is also the role of the school to intervene by referring students to community agencies and by using pupil services staff to provide supportive counseling when needed. The role of the community agencies is to intervene through their programs and to provide treatment services. As a team, schools and community agencies can provide activities and services which, when joined with other community and family support, form a prevention-based approach to resolving youth issues.

The local plan can be summarized in the following way.

Purpose

- To reduce the number of youth suicides by implementing the intent of the 1985 youth suicide legislation

Task

- Provide information to youth and adults which will encourage them to refer suicidal youths
- Provide youth with coping skills which will reduce the incidence of suicide attempts by providing alternate solutions to youth problems
- Provide intervention and treatment services

Method

- Develop a collaborative approach to serving youth which includes all community groups dealing with youth
- Develop classroom curriculum focusing on suicide prevention
- Develop suicide awareness workshops for youth

School activities

- Classroom curriculum development
- Pupil services program
  - —Identify suicidal students
  - —Assess suicidal risk
  - —Develop referral system

Community-based, school-focused activities

- Inservice for school and community professional staff, families, and other interested adults
- Awareness workshops for students
  - —Inservice for school and community staff
  - —Interagency Youth Issues Committee
  - —In-school support groups

Community agency-based activities

- Treatment of suicidal youth and/or families
- Consultation to school on at-risk students

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Luty, Carl. "The Language of Depression." *Todays Education* 71.3 (1982).

Wisconsin Prevention Network, P.O. Box 1092, Madison, WI 53701.

Table 1

Suicides and Attempted Suicides by Wisconsin Public School Students, 1982-85*

	Grade	1984-85	1983-84	1982-83	3-year Total
Suicides	K-5	1	1	0	2
	6-8	6	0	1	7
	9-12	42	28	34	104
	Total	**49**	**29**	**35**	**113**
Attempted Suicides	K-5	23	15	15	53
	6-8	219	142	105	466
	9-12	882	616	438	1,936
	Total	**1,124**	**773**	**558**	**2,455**

Outside Resources Used by Wisconsin School Districts to Deal With Youth Suicide

Agency	Number of Districts Using
County Department of Social Services	239
Mental health agency	204
Hospital	150
Private counseling	148
Law enforcement	63
Clergy	35
Public health nurse	36
Local physician	10
Other†	116
None indicated	38

†Includes alcohol and other drug abuse centers, runaway centers, pastoral counseling agencies, and county coroners

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**As reported by 344 school districts (of 432) in a 1985 survey by the Wisconsin Department of Public Instruction*

Table 2

Suicide Deaths by Age and Sex*

	Age	Three-Year Average		1981	1982	1983
		Number	Rate†			
Both Sexes	Total	593.0	12.5	584	579	616
	< 15	4.3	0.4	4	3	6
	15–19	53.0	12.7	51	54	54
	20–24	77.3	17.0	74	76	82
	25–29	72.7	17.8	75	69	74
	30–34	56.7	14.7	57	46	67
	35–39	42.3	14.2	46	46	35
	40–44	35.0	14.4	43	31	31
	45–49	38.7	18.9	28	44	44
	50–54	41.0	18.0	43	49	31
	55–59	40.7	17.2	50	30	42
	60–64	30.3	14.4	24	36	31
	65–69	30.0	16.0	34	24	32
	70–74	27.0	17.2	20	27	34
	75 +	45.3	18.4	35	48	53
Male	Total	464.0	20.0	436	463	493
	< 15	2.3	0.4	2	2	3
	15–19	45.7	21.8	43	48	46
	20–24	68.7	30.3	65	66	75
	25–29	58.7	28.5	59	56	61
	30–34	43.7	22.5	44	35	52
	35–39	28.7	19.4	30	26	30
	40–44	24.7	20.4	24	27	23
	45–49	27.0	26.7	19	32	30
	50–54	29.0	25.9	28	38	21
	55–59	27.3	23.9	35	18	29
	60–64	25.0	25.5	18	34	23
	65–69	22.0	26.5	22	19	25
	70–74	21.3	31.8	16	20	28
	75 +	40.0	44.4	31	42	47
Female	Total	129.0	5.4	148	116	123
	< 15	2.0	0.4	2	1	3
	15–19	7.3	3.5	8	6	8
	20–24	8.7	3.9	9	10	7
	25–29	14.0	6.9	16	13	13
	30–34	13.0	6.7	13	11	15
	35–39	13.7	9.1	16	20	5
	40–44	10.3	8.4	19	4	8
	45–49	11.7	11.3	9	12	14
	50–54	12.0	10.3	15	11	10
	55–59	13.3	10.8	15	12	13
	60–64	5.3	4.7	6	2	8
	65–69	8.0	8.0	12	5	7
	70–74	5.7	6.3	4	7	6
	75 +	5.3	3.4	4	6	6

*Wisconsin Department of Health and Social Services Report of Suicides in Wisconsin 1981-83

†Rate per 100,000 population (7-1-82). Rates calculated on fewer than 20 deaths are subject to large random fluctuations and should be interpreted with caution.

Community-Based, School-Focused Programming 2

Community-based, school-focused programming requires cooperation between the schools and the community agencies. Some basic principles (see below) need to be followed in setting up the local program. A major emphasis must be given to awareness efforts. Parents, students, and staffs from the schools and community agencies should go through intensive inservice training on how to recognize and appropriately refer suicidal youth.

Program Principles

As a result of analyzing existing successful programs and examining the available literature, the Wisconsin Department of Public Instruction has identified the following six principles as basic to an effective suicide prevention program.

- Local suicide prevention efforts must establish a working referral system between schools and community treatment groups.
- All agencies in a community which deal with youth should participate in designing the program.
- Special inservice training must be conducted for the staffs of schools and community agencies and families prior to introducing the awareness workshops to students.
- Student groups dealing with suicide awareness must be limited to 25 or fewer to enable time for dealing with emotional reactions to the subject.
- An in-school support system to assist students and staff in dealing with their feelings about this problem should be developed.
- A curriculum which encourages positive emotional development and problem solving should be developed and implemented. Personnel who are trained in techniques which facilitate the positive emotional development of youth should be actively involved in the development and implementation of this curriculum. This curriculum must emphasize
  - —skills needed to make sound decisions;
  - —knowledge of the conditions which may cause suicide;
  - —signs of suicidal tendencies;
  - —knowledge of the relationship between youth suicide and the use of alcohol and controlled substances;
  - —knowledge of the available community youth suicide prevention and intervention services;
  - —positive emotional development of pupils.

Awareness

Local youth suicide prevention programs should start by developing awareness of the problem. Adults and youth in a community must learn how to recognize and help individuals who are suicidal. A sound awareness program provides information on identifying the suicidal youth, assessing the seriousness of the situation or the risk, and referring the student.

Identifying the Suicidal Youth

Youth is a time of change: emotional, social, and physical. Young people face the uncertainty of being totally independent from their parents. Adults who care about teens need to realize that some of the signs of teen depression and suicide are signs of normal mood swings and are not unexpected for the maturing young person. The signs become significant when the adolescent feels:

Hopeless: A feeling of being unable to regain control of his or her life, that something will always be in the way of accomplishing goals.

Helpless: A feeling of not having the ability, strength, or intelligence to solve dilemmas.

Hapless: Seeming to float from crisis to mini-disaster to disaster without being able to avoid those situations.

Identifying Signs

The following are examples of suicide warning signs. The key is how the adolescent handles the stress represented by the signs.

sadness, the "blues"
self-blaming
feeling of worthlessness
slower than normal speech pattern
sudden change in appetite
weight loss without dieting
sleep problems
constipation
headaches
dizziness
problems breathing
restless feeling
withdrawal from friends
lack of concentration
physical or emotional fatigue
nervous gestures (tugs hair, rubs skin, pacing etc.)
loss of interest in appearance
expression of thoughts of despair
giving away of prized possessions
recent loss of girlfriend, boyfriend, pet, parent
death of someone close
use of drugs or alcohol
failure on a test, in sports, or in another extracurricular activity

Any abrupt change or intensification of behavior is a most siginificant sign which should concern people around a potentially suicidal youth.

Assessing the Risk

A person who recognizes the signs of suicide in another must decide what to do. In a society which values personal privacy and discourages even the appearance of interfering in another person's life, people generally do not feel comfortable taking action on someone's behalf. In the case of someone who is suspected of being suicidal, it is imperative to intervene. Take action by interviewing the youth.

- How **specific** is the person's suicide plan?
- How **available** is the method chosen to commit suicide? If they have decided to use a gun, for example, and they are from a family that hunts, the risk is high.
- How **lethal** is the method chosen? If they plan to use a gun or to hang themselves, for example, the risk is very high.

Remember the SAL method.

Specificity of the plan

Availability of the means

Lethality of the method

In general, three categories are used to classify potentially suicidal persons.

- Those who talk about their suicidal thoughts but have a low-risk SAL assessment. These youth are probably experiencing some depression due to problems with which they are having difficulty coping. It is important to give these youth support and to help them deal with their situations. Referral to community agencies *for those problems* may be indicated. The issue of suicide with this group is one to be considered but is probably dealt with best by concentrating on the resolution of the other problems.
- Youth who seem to be giving serious consideration to killing themselves but who have not yet made an attempt. These young people focus on suicide as a solution to their problems but they either have no plan or a very vague one. They need to be referred to community agencies and to school-based resources for help.

- Youth who have actually attempted suicide within the past few hours or who have admitted that they plan to do so in the immediate future. These individuals need immediate referral to mental health agencies within the community.

Referring the Student

Referral to in-school resources should occur when school staff become aware of students who are depressed and unable to handle their problems. The pupil services staff, and the school psychologist, social worker, counselor, and nurse are key resources. If the district has a student assistance program, that program can frequently make a significant difference in the student's life. The importance of the classroom teacher as an in-school resource is often overlooked. Teachers are frequently chosen by students as role models. A sensitive, caring teacher who works with the pupil services team can have a powerful impact on the life of a depressed student.

Referral to community agencies should occur when school staff are not able to provide the supportive services needed because the students are high risk or are in suicidal crises. These students must be referred for help immediately. Youth believed to be in danger of suicide need to be under observation by a responsible adult at all times until their parents or a staff person from a community agency take responsibility.

Referral to a community agency does not always work unless the school and the agency have agreed beforehand to specific procedures. School administrators and community agency administrators need to develop a written agreement which clarifies at what point students will be referred, to whom and when referrals will be made, and what response to a given referral can be expected by the school.

The referral process is designed to benefit the student. The safety of students is the guiding principle to follow in deciding what to do. Some students are not in suicidal crises, but are troubled. The pupil services staff and the classroom teacher or the administrator should involve the family in seeking help for the student. That help might be outside resources or supportive assistance within the school. A few parents will not be willing to allow a referral. If so, a decision must be made based on the perceived seriousness of the situation. It is always better to err on the side of making a referral too quickly than not quickly enough.

Emergency Referral Procedure

- Keep the student with a responsible adult at all times.
- Inform the administrator and/or the pupil services team of the problem.
- Inform the student's parents of the situation and advise them of the need for referral. If danger is high, proceed immediately to the next step.
- Inform the community agency of the need for immediate assistance.
- Stay with the student until the parents and/or the representative from the community agency arrives.
- Follow-up the referral by making direct contact with the student as soon as possible to express interest, concern, and continued acceptance. This follow-up should be done in the hospital if the student is admitted.

Inservice Programs

Following are outlines for staff and student inservice presentations. While an awareness program can be adapted to suit a particular school district, it should provide a workshop experience for adults and students within a set time period. These workshops are usually held in the school. Presenters can be from the school, county social services departments, 51.42 boards, mental health centers, and local hospitals.

Workshops for professional staff from school and community agencies usually require six to eight hours, while workshops for parents need only take two to four hours. The goal of the parents workshops is to familiarize them with how to recognize at-risk youth and how to help. For the professional staff, more time is needed to enable them to develop the skills needed to deal comfortably with students and the multiple-agency system set up to prevent suicides.

Staff Inservice on Teen Suicide

Staff who must deal with potential, threatened, or attempted suicides need to know about youth suicide and have confidence in their interviewing skills. An error in handling a suicidal student can be disastrous. The knowledge and skills needed to identify and refer suicidal youth are relatively simple to learn. Staff can be trained to recognize the danger signs and response skills needed to help prevent youth suicide. The following is a suggested outline for an inservice. Any school district inservice should include representatives from community agencies as presenters and participants. The material in this outline is intended to be used with material in Appendix E.

Statistics

400,000 people attempt suicide each year; at least 40,000 succeed (10 percent).

100,000 youth attempt suicide every year; at least 5,000 succeed (5 percent).

Suicide is the third leading cause of death for those 19 and younger.

Alcoholic youth are 58 times more likely to commit suicide than the general population.

One in six people who suffer from depression will eventually die of suicide.

An historical view

Romans had trained technicians to cut someone's veins.

Plato, Virgil, and Cicero condemned suicide.

Cato and Seneca felt suicide was acceptable.

Kant said, "Suicide is an insult to humanity."

Common Middle Age beliefs or practices
— A person who died by suicide was buried at a crossroads as a sign of disrespect.
— The body of a suicide victim was dragged through the streets.
— A stake was driven through the heart of a person who committed suicide.
— The body of a suicide victim was left outside the town to be eaten by carrion birds.
— If a pregnant woman stepped on a grave, her child would commit suicide.

A legal view

Early English law confiscated the property of the *survivors* (suicide kills a human; therefore, there must be punishment—you cannot punish the dead, so survivors must be punished).

Failed suicide brought imprisonment in England; in 1916, the law changed to placing the person in a relative's custody; by 1961, the criminality of the act was for all practical purposes eliminated.

A religious view

Life is good and God is behind all life; therefore, suicide is not acceptable.

St. Augustine declared it a sin.

In A.D. 563, funeral rites were denied In Europe.

In A.D. 673, burial rites were denied.

Many modern clergy consider both theology and psychic condition in deciding how to view the individual's suicide.

Definitions

Attempted suicide: a serious try that failed.

Suicidal gesture: attention-getting, a weak attempt.

Acutely suicidal: on the verge of committing the act; in suicidal crises.

Chronically suicidal: many attempts.

Hard-core suicidal: determined to die by suicide; does not give visual clues (about 2 percent of population).

Facts about suicide

Most adults do not realize the youth suicide problem.

Most youth who attempt suicide do not wish to die.

Youth often do not know how to ask for help.

Severe depression is a common factor in most suicides.

Severe depression is debilitating.

Severely depressed people do not have the energy to seek help.

Severely depressed people need someone to take over, to make decisions, and to get professional help.

Multiple causes of suicide
- Sense of worthlessness, low esteem
- Sense of hopelessness, no hope for the future
- Sense of haplessness, too many bad things have happened
- Sense of helplessness, feeling powerless to change things

Background characteristics of suicide victims
- Early separation from parents
- History of family instability (physical or sexual abuse, economic problems, alcohol or other drug problems)
- Family history of suicide
- Loss of a job, marriage, friend
- Public humiliation
- Problems with police

Differences between sexes
- Females of all ages make more attempts; males succeed more often
- Females tend to use pills; males tend to use more violent means such as guns or strangling devices
- Males and females are becoming more alike in methods and rate of success

Reasons children give for attempting suicide
- To get attention
- To avoid punishment
- To escape pain
- To punish someone

Characteristics suicidal people have in common
- Number of suicides increases with age.
- Teen suicide up 200 percent in last ten years.
- Suicide rate higher in Western U.S.

Racial characteristics of suicide victims
- Suicide rate higher among whites than blacks
- Native American suicide rate is epidemic in 15-20 year age group

Time of year suicides occur
- Spring is popular time for suicide
- Christmas rate high because expectation of joy does not match reality

Indicators of teen suicide (look for a cluster of signals)

Sudden personality change

Increased alcohol or other drug use

Giving away possessions

Eating/sleeping disturbances

Neglecting personal appearances

Sadness that does not lift

Verbal cues

Withdrawal from family, friends, activities

Difficulty making even minor decisions

Alcohol and other drug involvement

Alcohol and other drug use among depressed teens is *epidemic*.

Drug use tends to reduce normal inhibitors against self-destruction.

Kids tend to self-medicate against depression at an alarming rate.

Alcohol is a depressant drug.

Behaviors which mask teen depression

Truancy

Running away

Neglecting school work

Violent behavior

Related facts regarding teen suicide

Teens act on their *perceptions* of their situation—not on reality.

Many succeed accidentally, because of a miscalculation.

Teens tend to commit suicide impulsively.

Teens tend to tell their friends rather than adults about suicidal thoughts.

Because of limited life experiences, teens think their pain will not go away.

Myths about suicide

Most people who commit suicide are crazy.

Once someone decides on suicide he or she cannot be stopped.

The suicidal tendency is inherited.

Most suicides happen at night.

Those who commit suicide usually leave a note.

Talking about suicide gives people the idea.

Importance of school staff response to potential or threatened student suicide is important.

They can observe student behavior that indicates depression.

They can listen to students who want to talk about their concerns.

They can provide a calm and trusting atmosphere for a troubled student.

They can take the student to someone who can deal with the crisis.

They can understand that students need adults but may not be able to ask for help.

They can, most of all, let students know that they care about them.

Assessing the suicidal threat – SAL

Specificity of the plan. The more detail the higher the risk.

Availability of the method. If youth are easily able to obtain the means to kill themselves, the risk is high.

Lethality of the method. Guns and hanging are the most lethal, taking one or two aspirins the least. The more lethal the method, the higher the risk.

Any professional staff member can use this method to determine whether a student should be referred.

Referral

School staff may use pupil services staff or community agencies.

If there is any suspicion that a student is suicidal, the building administrator, the student's parents, and a predetermined agency should be notified.

The suicidal student should not be left alone until the appropriate community agency and/or the student's parents accept responsibility.

Audiovisuals and discussion

Suggested audiovisual materials are "But Jack Was a Good Driver," "Three Who Chose Life," and "Why Did Jenny Have to Die?" See Appendix E for complete information on these resources. *If filmstrips are used, allow at least 1½ hours for the workshop.*

Use handouts listing signs of suicidal behavior (Appendix D).

The role of the school is to educate students and teachers about suicide and tell them where to get help in school and in the community. Students need to realize that if a friend talks to them about suicide, they should not keep it a secret but take that friend to a concerned adult.

Summary

Teen years are rough times for kids.

There are many fractured, dysfunctional families.

There is great pressure on kids to succeed.

Kids hurt in ways adults are unaware of.

They feel isolated and alone.

We need to assure them they will eventually feel better.

There is help available to get through the crisis.

Outline developed with the assistance of Joan Moen, school social worker, La Crosse School District.

Student Inservice on Teen Suicide

An effective adolescent suicide prevention program includes a specialized effort to increase student awareness in recognizing and intervening when they know or suspect a friend is suicidal. The literature shows clearly that youth seek out other youth when they need assistance with problems. Adults in helping professions and parents are far down the list for troubled students to turn to for assistance.

Students need much of the same information described in the staff inservice outline, but not as much emphasis on the statistics, societal attitudes, and legal aspects. They need to know how to recognize the signs of a potential suicide and what to say and do if they feel a friend needs help. This outline can be used as part of the district/community awareness inservice to students.

Information dealing with death, especially death by suicide, is very emotional. Therefore, the ideal group size for a suicide prevention presentation is 12 to 15. Groups of more than 30 are not appropriate unless there is an opportunity for smaller discussion groups.

Presenters must be comfortable dealing with both the topic and with youth. The combined skills of teachers, pupil services staff, community mental health workers, and county social services workers are invaluable for presenting the material.

Suicide facts

Nationally, 5,000 students, 19 and younger, die by suicide each year.

50 to 60 students in Wisconsin, 19 and younger, die by suicide each year.

At least 850 students in Wisconsin attempt suicide each year.

More girls attempt suicide than boys, but more boys die by suicide than girls.

Suicide is the result of the accumulation of many problems, including alcohol and other drug abuse, home or school problems, loss of friends, growing up, and low self-esteem. The suicide can be prevented if help is available.

Most people who attempt suicide

- do not want to die, they want help;
- are not crazy;
- if they get help, do not try it again.

Audiovisuals and discussion

Suggested audio-visual materials are the 16mm film "But Jack Was a Good Driver," and the filmstrips "Three Who Chose Life," and "Did Jenny Have to Die?" See Appendix E for complete information on these resources. *If filmstrips are used, allow at least 1½ hours for the workshop.*

Use handouts listing signs indicating suicidal behavior to aid discussion (Appendix D).

How to help

If someone talks to you about committing suicide, do not keep it a secret. It is better to have a live former friend than a dead friend. Remember, the suicidal person is asking you for the best help you can give and expects you to call others to help.

Always deal with a suicidal friend by getting an adult you trust involved as fast as possible.

Take, do not send, your suicidal friend to help to be certain the friend really goes, or bring the adult to the person.

After you have taken your friend to help, be sure no one gossips about your friend's troubles.

Once your friend is being helped, do not forget him or her. Contact the person daily. Ask your friend how he or she feels. Listen. Care.

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Planning and Implementing A Prevention Program 3

Introduction

An effective youth suicide prevention program requires the cooperation of agencies and individuals systematically approaching the problem.

Those agencies who will be affected and expected to have a role in the implementation of the program need to be involved in the planning.

The successful programs are relatively simple to operate; in fact, some of them can be developed almost overnight, but they may take 10 to 14 months to become fully operational. This timeframe allows for very specific problems to be resolved, including:

- fear of the general community and agency professionals that talking about suicide will cause students to commit suicide;
- fear of parents that suicide awareness training for students will intrude on their parent-child relationships;
- preparation of agencies for increased referrals of troubled students;
- establishment of the interagency relationships which will insure that students will have resources needed to help them when they are in crisis.

This section presents a step-by-step description of a process that will prepare agencies and the community for an effective youth suicide prevention program.

Planning Process

Step One: Gather Data and Information

Programs begin when one or two people are concerned about a problem and begin to share their concern with others. A natural group forms and develops a knowledge base to use to suggest needed change. Anyone can begin or be a part of this natural group.

The issue of adolescent suicide has stimulated a great deal of research and general information articles. Statistics that describe the extent of the problem on a national, state, and local level can help define the extent to which a school district and community need to concentrate on programming. Once a decision has been made to invest time and resources in youth suicide prevention, the group should become familiar with the causes and characteristics of the problem, and find out what other agencies and communities have done to develop prevention programs. Models of existing programs may then be used in part or whole as a basis for constructing an approach appropriate to a specific community.

Data on the extent of the problem of youth suicide may be obtained from several sources. The Wisconsin Department of Health and Social Services collects statistics on accidents in the state, and includes an addendum specific to suicide. The Wisconsin Department of Public

Instruction has collected information from districts that maintain prevention programs, has an updated bibliography on suicide, and provides technical assistance to school districts wanting to develop suicide prevention programs. Contact with each may be made at the following addresses:

Director of Pupil Services
State Department of Public Instruction
125 South Webster Street
P.O. Box 7841
Madison, WI 53707
Telephone: (608) 266-8960

Director of Community Services
State Department of Health and
Social Services
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707
Telephone: (608) 266-2701

Additional sources of information are local law enforcement agencies, coroner's offices, clergy, mental health agencies, county department of social services, and school pupil services staff.

Step Two: Obtain Administrative Support

It is essential to the development of a community-based, school-focused youth suicide prevention program to obtain the support of the administrators of the schools and the community agencies early in the planning stage. The data gathered in step one may be used to support the need to develop a prevention program and to illustrate what other communities have done. Each school district and community will follow its own process to establish approval for developing a program. The school district administrator, school board, and building principals, as well as the community agency administrators and boards, must be contacted before specific proposals are made or action taken to involve them in a program. Inclusion of these leadership sources in the initial stages of planning will provide the support needed for program implementation. The school board and the boards of other involved community agencies must pass policies and procedures (pp. 21-23) supporting the development of a youth suicide prevention program in the community and district.

Step Three: Form an Ad Hoc Youth Suicide Prevention Committee

Youth suicide is a community problem. No one agency can effectively deal with it. For that reason, the community must be involved in a collaborative effort. During the time spent gathering data, various people in the community will have emerged as being concerned with the problem. These people will, in turn, have a knowledge of others who have the time and skill to participate in developing a suicide prevention program. A list can very easily be put together of names of helpful people, their available time commitment, knowledge and skill in the area, and positions within the community. This list should include representatives of education, mental health, public health, law enforcement, the county department of social services, voluntary social service agencies, service clubs, the clergy, and business (see Appendix A). Direct contact by phone, letter, or in person should be made with these people, asking them to serve on an ad hoc committee on youth suicide prevention. Soon after making a commitment to serve, they should receive the data and information which have been collected, and within two weeks the new committee should meet.

Step Four: Assess Agency Resources

If the ad hoc committee does not already include all of the administrators of the various community agencies, approach them to determine the degree of support which can be expected from their agencies. To be most effective, two to three members of the ad hoc committee should approach each administrator. Then, after deciding what is to be done, who is to do it, and how is it to be done, recontact the elected officials who will be involved in the program. Members of the school board, county social services board, county law enforcement committee, and the mental health board need to be informed of the proposed Youth Suicide Prevention Program. At this time the school board should establish a youth suicide prevention policy which reflects its commitment to the program. The initial steps of this process deal heavily with building the support necessary to establish an effective, ongoing program. During this time, the committee will get an idea of the kinds of obstacles, if any, the program will face.

Step Five: Assess Community Resources

By relating available data and information about adolescent suicide to the community's characteristics, the committee can determine what type of effort will best fit the needs of the community. The committee should consider

- the number of youth suicides and attempted suicides in the past three to five years;
- service agencies available to the community;
- income and educational levels of adults;
- available educational opportunities;
- available financial support;
- expected community reaction to the program;
- political processes necessary to gain program approval.

When the ad hoc prevention committee has determined the answers to these questions, it can begin to design and implement a program, being aware of the difficulties that might arise. (See the General Community Assessment sheet in Appendix B and a sample General Community Assessment at the end of this section.)

Step Six: Formulate an Action Plan

The ad hoc committee must formulate an action plan designed to implement its Youth Suicide Prevention Program. (See the Action Plan Form in Appendix C and a sample Action Plan at the end of this section.) The committee members must insure that any individual or agency involved in the program's implementation understands and agrees on which staff will do what task and on who will pay associated program costs. Agency administrators and their citizen boards need to be well informed about how the program will affect them in increased referrals and financial costs. As the action plan is developed, great care must be taken to keep people informed of the plan's progress. Each party to the plan must understand and agree to it before implementation begins.

All members of the ad hoc committee should have a copy of the plan and specific assignments. The primary task of the ad hoc committee member at this point is to anticipate and help avoid the inevitable problems, such as workload conflict, which occur when special projects are developed.

The suicide prevention program should include both primary and secondary prevention components. Primary prevention efforts should include plans to develop curriculum emphasizing positive emotional development, successful problem solving, and information about community resources for all types of assistance. School staff and parents should be inserviced on how to recognize and prevent ordinary anxiety developing into clinical depression. Secondary prevention should focus on inservicing staff, parents, students, and community agencies on the incidence and causes of suicide and treatment methods. A comprehensive effort to identify at-risk individuals, insure their referral, and provide for their treatment is essential.

The following districts are involved in youth suicide prevention efforts. Their programs are described elsewhere in this manual as representative samples of local programs considered to be effective.

La Crosse Public Schools
807 East Avenue South
La Crosse, Wisconsin 54601

Cedarburg Public Schools
W68 N611 Evergreen Boulevard
Cedarburg, Wisconsin 53012

Whitnall School District
500 South 116th Street
Greenfield, Wisconsin 53228

Shawano School District
204 South Franklin Street
Shawano, Wisconsin 54166

Step Seven: Implement

Implementation of the plan represents the culmination of the committee's efforts. The committee should appoint two or three of its members to keep close contact with those who are doing the implementing. These two or three contact people can provide progress reports to the rest of the prevention committee, call meetings of the committee to resolve problems, and locate resources for the implementors when they need help.

Step Eight: Evaluate

The ad hoc committee should evaluate the effect of its efforts on the at-risk adolescents and determine if the method and model used were appropriate for the problem and the community. Signs which indicate the effectiveness of the program include

- an increase in the number of referrals of suicidal youth to mental health resources;
- an increase in the understanding of teachers, parents, mental health professionals, and the general public about the signs, causes, and prevention of adolescent suicide;
- a possible reduction in the rate of attempted and completed teen suicide. This measure will at best be an elusive piece of information which, in all probability, will not be detectable for a number of years.

Once an evaluation has been done, the committee should determine what modifications, if any, need to be made in the prevention plan and then plan for monitoring these efforts.

Step Nine: Maintain the Program

Maintenance of the prevention program is essential to realize its potential benefits. There will be only limited value in a single suicide prevention campaign, even if it occurs on a yearly basis. New groups of at-risk adolescents develop each year. The proper maintenance of a suicide prevention program should include awareness and prevention education for community, professionals, parents, and adolescents. Awareness is the most commonly recognized prevention effort. A community conducts a campaign which highlights the problem and the available resources for treatment. Prevention includes awareness but also deals with self-concept and effective problem solving for adolescents. Students and adults need to be reminded that suicide is a problem for which they share a preventative responsibility and for which help is available.

Sample Forms

In any planning process, it is helpful to have a set of forms which can be used to guide the work of the committee. Samples are included in this section.

The samples of policy and procedures that follow were prepared from those in use in Wisconsin school districts. They contain the basic essentials and can be modified to apply to most districts. The adoption of policy and procedures by the school board gives a clear message of support for the program and provides needed direction.

Frequently, one of the most difficult tasks in the planning process is to determine who can be helpful. The *Community Resources Network* sheet provides the structured opportunity to consider many individuals representing a wide spectrum of the community. The type of people suggested on the sample form will not be the same in all communities. However, it is important to have as many different community groups represented as possible.

Each community has unique characteristics which can be used to enhance the human resources available. The demographic characteristics of the area will play a role in what type of program will work best and how it can be introduced successfully to the community. The *General Community Assessment* sheet gives the planning committee the means to consider the community assets.

Discussions of the planning group should be reduced to a written plan which assigns timelines to individuals to accomplish specific tasks. The *Action Plan Proposal* provides one way to explain to the boards of the cooperating agencies what is expected of their agencies. The plan, along with a budget proposal, should be submitted to agency administrators for their use in obtaining support from their boards.

The model suicide prevention policy and procedures have been developed pursuant to ss. 15.377(7), 20.255(2)(fs), 115.365, 118.01(2)(d)7, and 118.295, Wis. Stats., and are based on existing, successful suicide prevention programs both in Wisconsin and the nation.

Model ■

Suicide Prevention Policy

School District of ____________________

It is the policy of the ____________________ school district to develop an effective youth suicide prevention program. The district suicide prevention program shall include:

1. A written agreement of understanding between the __________________ school district and the following community agencies:
    a. 51.42 Board
    b. County Social Services Department
    c. Local law enforcement agencies
    d. ____________________ hospital
    e. Private counseling services
        1)
        2)
        3)
        4)
        5)

    to assist in inservice of ____________ district staff, presentation of relevant material to students, and presentation to parent groups, emergency services (including medical and crisis intervention services); and to accept other related referrals. The agreement shall spell out staff time, fiscal responsibility, and other conditions of referral.

2. The provision of a yearly inservice program for new and/or continuing staff members. Staff means any professional, paraprofessional, tradesperson, or support person employed full- or part-time by the district. Inservice shall contain the following information:
    a. Recognizing the suicidal youth
    b. The relationship of AODA, teen pregnancy, abuse, sexual abuse, and other youth issues to suicide
    c. Available resources to help suicidal youth
    d. How to refer suicidal youth to help

3. The designation of the building principals and the pupil services staff as primary contact people for all other district staff who wish information on youth suicide or to refer a suicidal student.

4. Adoption of the following principles germane to a sound youth suicide prevention program.
    a. All community agencies dealing with youth will be invited to help plan the suicide prevention program.
    b. A working referral system will be developed immediately and updated as needed.
    c. Staff and students will be given inservice in youth suicide prevention.
    d. Students will be given an opportunity to discuss youth suicide in small groups of less than 30 students.

Moved for Adoption by:

Seconded by:

Passed: ____________________
(date)

Signed: ____
School Board President

____
District Administrator

■ Model

Suicide Prevention Procedures

School District of ____________________________

When any person employed by the school district of ______________________________ shall have reason to believe, either by virtue of direct knowledge or a report from another person, that a student is in any danger of harming him- or herself through an attempted suicide, or has attempted suicide, that person is to report the situation immediately. The procedure to report this situation is as follows.

1. Contact the building principal and/or a member of the pupil services staff. *Do not leave the suicidal student without adult supervision for any amount of time while making this contact.* If the student's life is in imminent danger, summon law enforcement personnel to transport the student to the nearest hospital emergency room.

2. The building principal and the pupil services team shall contact the student's parents and request that they meet with the school staff immediately. The parents shall be informed that their child has attempted, or is planning to attempt, suicide. This meeting may take place at school, at the 51.42 board's office, at the county department of social services agency, or at a hospital depending on the danger to the student's life. The building principal shall determine the location of the meeting.

3. If the danger to the student is not imminent, the principal and/or the pupil services team shall determine if it is appropriate to involve the county department of social services and/or the 51.42 board at this time or to urge the parents to involve these agencies.

4. When any outside agency is to be used, a release-of-information form shall be signed which will allow a two-way flow of information between the school and the community agency.

5. After the *immediate* crisis has been resolved, the principal and the pupil services team shall meet to evaluate the situation and decide on an appropriate role for the school to take in assisting the student. This group shall appoint a member to be case manager to keep close contact with the student and the community agencies treating the student to insure a coordinated school-agency approach.

6. All teachers involved with the student shall be invited to an informational staffing to assist them in appropriately dealing with the student.

7. The pupil services staff person assigned as case manager shall maintain a written record of all actions taken by the school in the case and shall perform a monitoring and follow-up function to support the student and assist the teachers after the student returns to class. The case manager should maintain weekly contact with parents during a 90-day time period after the referral.

8. The case manager shall make a report to the building principal and pupil services team at the end of 90 days to clarify the status of the student at that time. The principal and the pupil services team shall determine what, if any, further action shall be taken.

9. The case manager shall meet with the student's parents to inform them of the decision of the school staff on district follow-up and to obtain their reaction.

Contact agencies to use are listed below.

AGENCY	PHONE NUMBER
51.42 Board	
County Department of Social Services	
Law Enforcement	
Hospital Emergency Room	
Ambulance	
Private Counselors	
1.	
2.	
3.	
4.	

■ Sample

Community Resources Network Sheet

School

1. Jane Wornish, Superintendent
2. Alice Carpenter, High School Principal
3. Val Locus, School Social Worker
4. John Benish, School Counselor

CESA

1. Arlene Smith, Human Growth and Development Coordinator, CESA 2
2. Patrick Ryan, Human Growth and Development Coordinator, CESA 3
3.

County Social Services

1. Ben Georges, Director
2. Getty Casin, Supervisor
3.

Public Health

1. Nancy Fons, PHN
2.
3.

Private Agency

1. Ed Beglas, Director, Family Services Assn.
2. Margaret Atlas, Social Worker, Lutheran Social Services
3. Ansel Jones, Social Worker, Catholic Social Services

Medical

1. Dr. Alfred Wheems
2.
3.

Law Enforcement

1. Sheriff Joe Frank
2. Police Chief Richard Wheems

Private Business

1. Jack Ballis, IGA
2. Sam Nance, Burger King
3. Gabrielle Smith, Western Insurance Co.

State Agency

1. Jason Jackson, Regional Office, Wisconsin Department of Health and Social Services
2. Alan Johnson, State Office, Wisconsin Department of Health and Social Services
3. Mary Dickson, Wisconsin Department of Public Instruction

Church

1. Rev. Frank Blasingame, St. Paul's Catholic Church
2. Rev. Alex Smith, Midtown Baptist Church
3. Rev. Thor Torgerson, St. Stephens Lutheran Church

Private Citizen

1. Ann Alsteen
2. Richard Dent
3. Jack Fritz

Mental Health

1. Al Peterson
2. Dr. John Altacks
3.

Students

1. Jane Alsteen
2. Bob Benson

Names and titles are listed to give an idea of how this form would look when completed.

General Community Assessment

Population

Overall 25,000

Males 10,000

Females 15,000

School age 7,350

Males 3,100

Females 4,250

Number of youth suicides in last 3 years 3

Number of youth suicide attempts in last 3 years 12

Income

under $10,000 8,000

$10,00-25,000 13,900

$26,000-49,999 3,000

$5,000-over 100

Schools

Number of High Schools 1

Number of Middle Schools 2

Number of Elementary Schools 3

Major Employers

Smiths Gasket

Benson Brewery

WISCON Insurance

School District

Adult Population's Education Level
(estimated)

Less than High School 2,650

High School 12,350

Technical School 1,800

College 600

Graduate School 250

Potential Financial Support Resources

WISCON Foundation

County Board

City Council

Recreational Opportunities

Lakes and Swimming Pools

Skating Rink

3 movie houses

Pool hall

Bowling alley

Service Agencies in Community

County Mental Health

County Social Services

Lutheran Social Services

Catholic Social Services

Jaycees

■ Sample

Action Plan Proposal

To: School Board, 51.42 Board, County Social Services Board

From: Ad Hoc Suicide Prevention Committee

Subject: Suicide Prevention Action Plan

The ______________________ ad hoc suicide prevention committee has developed the attached plan to establish an adolescent suicide prevention program in our community. The plan is being submitted to you for your information, modification, and support. In some instances you will note that the plan contemplates some expenditures. All these expenditures have been previously discussed with the administrators or elected officers of the indicated resource. We would appreciate it if you would review your agency's initial agreement to provide this financial or in-kind support and notify us as to whether that support is still possible.

Our present plan is to use the Cedarburg, Wisconsin, plan, modified to fit our community's needs. The following steps will be taken.

- All agency heads and boards will be advised of the ad hoc committee's plans and their final input requested.
- The mental health clinic staff and the pupil services staff of the ____________________________ school district will coordinate and present a training program on suicide prevention to the school staff, mental health staff, law enforcement, parents, and students over the next four weeks.
- The following handouts will be made available to professionals, parents, and students. The approximate cost of these materials is $200.
  - —"Preventing Suicide" (booklet from *Sun* publications)
  - —"Warning Signs" (booklet developed by ______________________ school-community committee)
  - —"How to Refer Someone for Help" (mental health pamphlets developed by County 51.42 Board)
  - —"Starting a Suicide Prevention Program" (DPI Guidelines manual)
- Two films will be shown. Rental cost of these films is $15.
  "Why Did Jenny Have to Die?"
  "But Jack was a Good Driver"
- Manuals have been prepared and will be duplicated in sufficient numbers to provide each student, parent, and professional with a copy. The cost of manuals will be $300.00.
- 175 posters and announcements have been prepared and will be printed at a cost of $250.
- Estimated cost of the program is $961 (see attached budget).

Attachment: Proposed budget

cc: Agency Administrators

Sample ■

Action Plan Budget

ITEM	AMOUNT	SOURCE	
Handouts	$200.00	CESA	$100.00
		Jaycees	$100.00
Films	15.00	CESA	$15.00
Manuals	300.00	CESA	$300.00
Posters and Announcements	325.00	Kiwanis	$250.00
		County Social Services Dept.	$75.00
Speakers	100.00	Mental Health Board	$100.00
Coffee, etc.	21.00	County Social Services	$21.00
TOTAL	**$961.00**		

Budget by Source

CESA	415.00
County Social Services	96.00
Mental Health Clinic	100.00
Jaycees	100.00
Kiwanis	250.00
Total	$961.00

Sample

Action Plan Task Assignment

DATE ____________________

Task	Person Responsible	Timeline	Cost	Cost Charged to
Review model with	Ad hoc		in-kind	
Administrators and Boards of	committee			
		2 weeks		
School District		2 weeks		
Mental Health Agency		2 weeks		
County Social Services Dept.		3 weeks		
Local Law Enforcement Agency				
Inservice for community adults,	Val Locus	3 weeks	in-kind	school/mental health
school and agency professionals,	Ansel Jones	3 weeks	"	"
students	Al Peterson	4 weeks	"	"
		3 weeks	"	"
		4 weeks	"	"
Materials	Wilson/Ad hoc Committee	2 weeks		
AV equipment		"	in-kind	school
Meeting place	John Benish	"	"	school
Mailings	John Benish	"	"	
Films/video tapes	Getty Casin	"	$15.00	CESA
Manuals	Arlene Smith	"	$300.00	CESA
for trainers, for committee, for school, for mental health	Arlene Smith	"		
Printed Materials	Patrick Ryan	"	$100.00/$100.00	CESA/Jaycees
for parents and students	Arlene Smith			
Posters for referrals	Kiwanis	"	$250.00	Kiwanis
Media	Joe Frank	4 weeks	-0-	
Announcements	Ben Gerrges	as needed	$75.00	County Social Services
Special Speakers	Al Peterson	4 weeks	$100.00	Mental Health Agency
Refreshments	Getty Casin	as needed	$21.00	County Social Services

Postvention: Preventing the Cluster Phenomenon

4

Dealing with the Aftermath

Despite all good efforts, all youth suicides will not be prevented. When a youth suicide occurs, the community needs to deal with two immediate problems. First, one suicide can lead to another. Such "cluster" suicides, observed and described in the popular press and in the literature, occur because the first suicide may trigger others. Second, the grief and shock of the family, friends, general school population, and the community-at-large must be dealt with. Youth, especially, need help in talking about the suicide and how they feel about their own problems. They need a chance to learn, or relearn, that it is normal for them to think about suicide but that thinking about it does not mean they are destined to die by suicide. They need a chance to deal with the grief they feel. How a district handles the aftermath, or postvention, of a youth suicide can prevent the cluster phenomenon and help the community deal with grief.

Students will talk about the suicide whether or not the school provides them with the opportunity. If they talk about it without adult leadership, their conclusions may not be as helpful to them as they need. The adult leadership can turn the situation into a helpful one for others who might be thinking of suicide.

Postvention Steps

- The district administrator or the building principal should brief the classroom teachers and the pupil services staff on the situation.

- The district administrator should request assistance from area 51.42 board(s), the county department of social services, and other school districts in the form of psychologists, nurses, social workers, and counselors who could spend a day in the district talking to small groups of students about their feelings and reactions to the suicide.

- All first-hour or homeroom classes should be given the facts of the situation and an opportunity to have a short discussion of their feelings. They should be informed that small group sessions will be held within 24 hours (preferably the same day) for all students, that district pupil services staff and/or community agency staff will be available for individual sessions as needed. The time, place, and adult leader of all sessions should be identified.

- The immediate peer group of the student who has died by suicide needs to be identified and called in at once for special sessions with pupil services and/or community agency staff.

- All students need to be informed as to whom to ask for help if they or a friend are thinking of suicide.

- Support groups should be scheduled for those who need them during school time.

- These general rules should be followed.
  —Do not dismiss school. The students need to follow as normal a pattern as possible.
  —Do not encourage a general student body attendance at the funeral if it is held during school hours. Excuse only those students who have a parental request for an excused absence for the funeral.
  —Do not dedicate a room, garden, or street to the student's memory.
  —Emphasize that suicide is not a good choice to solve problems, that help is available, that people care.
  —Emphasize that no one is to blame, not friends, parents, or teachers. The person chose to die by suicide, and no one forced it on that person.
  —If students or staff want to do something, suggest helping to plan a suicide prevention effort in the community, but discourage any memorials.
  —Do not schedule a large assembly.
  —Do provide small group opportunities to discuss the student suicide.

Model Programs

Cedarburg
La Crosse
Whitnall
Shawano

This section contains descriptions of four school and community adolescent suicide prevention programs. These four programs are considered to be especially effective and have been selected as illustrative models for other school districts and communities to consider for adaptation or adoption. Each of these programs was originally developed to deal with various youth issues but has been modified to also deal with suicide prevention. These programs are presented for a variety of reasons.

- *The structure of these programs is administratively sound.*
- *The skills and knowledge needed to work with students exhibiting youth-related problems are by and large the same as those needed to deal with suicide prevention.*
- *Existing service delivery structures identified in the model programs can be expanded to deal with youth depression and suicide problems.*
- *The programs recognize that students who are at risk of suicide are in need of a variety of other services in such areas as pregnancy prevention, neglect, or abuse.*

Cedarburg: A Community-Based, School-Focused Approach

5

Overview

Cedarburg's youth suicide prevention program is an example of a school district's collaboration with a mental health agency to provide help to students. The approach used is community-based, school-focused with a strong emphasis on the inservicing of staff and students. It illustrates the specific activities which must be undertaken in planning, providing inservice for staff and students, and establishing a referral system for students who are identified as needing help. This program demonstrates more clearly than most the six principles which should be followed to reduce the rate of youth suicide (see page 9).

The Cedarburg Suicide Prevention program was developed in a climate of urgency. During the 1983-84 school year the increased rate of adolescent suicide in Wisconsin was acknowledged by some school staff as a topic which needed to be discussed with faculty. The result was a ten-minute presentation at a faculty meeting in the spring which briefly described the problem and gave some information about where to seek help.

Tragically, approximately two months later, a sophomore boy went home from school at lunch time and shot himself. Feelings of grief and guilt stunned the community, faculty, and students. People saw this as a preventable death. The young man had given many of the classic warning signs, but no one had put the pieces together in a way that led to identification of this boy as a potential suicide victim. The community reacted with a strong desire to prevent the reoccurrence of so painful an incident. During the summer months, the high school principal, with the support of faculty and community members, took the initiative to form a committee to address the problem of adolescent suicide and depression.

The community was involved in the prevention program in many ways, beginning with the planning process. Police, alcohol and other drug abuse counselors, clergy, and school board members were invited to a faculty presentation. Several local newspapers ran articles about the topic of adolescent depression and suicide with specific references to what was being done in Cedarburg. A local television news station made a brief report about the program. The clergy invited the school social worker and psychologist to meet with them regarding the prevention program. In that meeting, information was shared and questions were answered about the interplay of the roles of school staff and clergy.

Several benefits accrued as a result of the community-based approach to suicide prevention. The concept of *shared responsibility* among the adults in the community could be seen in the increased cooperation in handling referrals of students who needed help. Also, ongoing working relationships with public and private mental health providers were enhanced through increased awareness of the added need for accessible services. The continual availability of community resources is a necessary component of a comprehensive plan.

Committee Formation and Plan

Membership of the committee included some highly motivated people: the minister of the boy who died, the mother of a college freshman who had died of suicide several years earlier, the president of the parent advisory council, and the director of the county mental health center. Faculty membership included administrative staff, a school counselor, school psychologist, and school social worker. Members brought to the committee a variety of experiences, points of view, and ideas. Everyone acknowledged a need for further study and discussion. Slowly a consensus developed, and an overall plan was formed which became more detailed and finely tuned during the year. Continuity and momentum were maintained by meeting every two weeks and by administrative support. The high school principal made the suicide prevention program the highest priority for the school year.

The first task was to place a notice on all bulletin boards throughout the high school giving information about resources for help with emotional problems. This was done as a temporary measure until the program could be developed. It was also decided that the committee would become the school's emergency crisis team if an event occurred requiring schoolwide intervention.

The committee's efforts were based on the premise that the key to prevention is the identification of potentially suicidal students. While the ambivalence of most suicidal people leads them to behave in ways which incorporate warning signs of their intentions, these signs are often disregarded by people who are unaware or not emotionally open to their possible significance. For this reason, the prevention program needed to involve all those who interacted with the potentially suicidal student. It needed to give them information in a way which could break through their emotional resistance and give them practical knowledge.

The committee's plan was comprehensive, establishing as targets for intervention the faculty, parents, students, and other members of the community. A variety of teaching techniques were used in large group presentations and small group discussions. Guest speakers gave presentations, staff served as facilitators, and films were shown. Among the written materials used and distributed were pamphlets, case examples, suicide letters, pre- and post-inservice surveys, and newspaper articles.

Committee on Teenage Depression and Suicide

Cedarburg High School

Jerry Thomas	Principal
Brian Scheunemann	Vice Principal
Jon Ehle	Instructional Coordinator
Claire O'Brien	School Counselor
Jacquie Sellin	School Social Worker
Marlene Cory	School Psychologist
Pastor Ron Mach	Faith Lutheran Church
Janet T.	Surviving Parent
Jo Shoemaker	Parent Advisory Committee
T. Allan Pearson	Ozaukee County Counseling Center

(These people also make up the Crisis Intervention Team within the school district.)

Cedarburg High School

To: Staff

Re: Crisis situations that may arise in a student's school, social, or home life

From: Jerry Thomas

Date: September 14

Given the number of crisis situations that have confronted our students individually and as a group over the past few months, it seems imperative that we all be aware of the fact that many people are available for students facing crises to talk with in a confidential setting. Also, it should be known that staff members confronted with problems of students can get direction from many of the same sources.

I ask each teacher to post the attached sheet and call the attention of the students to the information it contains and the purpose for such action as outlined above.

A few words of caution would be that joking comments about student problems of any nature are not appropriate and problems of individual students must not be discussed in other than a professional context.

We presently have a committee working on preparing an inservice for staff in the area of student depression, suicide, abuse, and emotional crises. The committee consists of professional, school, and community individuals. More information will be forthcoming as the program develops.

Attachment

Student Information Poster

Sources Available for Help

Adolescence is a time of a great deal of emotional pressure. Students who become overwhelmed with stress often experience the following problems:

Emotional Crisis
Sadness
Fear of abuse or violence
Suicide
Alcohol and other drug abuse

If you know anyone who may be experiencing one or more of these problems, encourage that person to contact one of the following sources, or you can help him or her by contacting the following sources:

1. Any teacher, adult, or friend
2. Mr. Ketter
   Miss O'Brien
   Mr. Helm
   Mr. Hoff
   Mr. Scheunemann
3. Advisor
4. Cope Hotline — 963-0838
5. Cedarburg Schools Special Services — 375-2303 or 375-2309
6. Cedarburg Police - 377-2242
7. Sheriff's Department
   Ozaukee County — 377-5820
   Washington County — 342-3537 or 1-338-4411
8. Ozaukee Council on Alcohol and Other Drugs — 377-1110
9. Priest or pastor

(Remember, confidentiality is important; however, when someone is in danger, **help is more important!**)

PLEASE POST

Faculty Inservice/ Large Group

The faculty was the first point of intervention. They were seen as the support system which would need to be able to respond to crises as they occurred within the school. Objectives included:

- sensitizing faculty to the problem in a way which allowed them to shift from a cognitive perception to an affective perception of a suicidal teen;
- promoting understanding of warning signs to facilitate identification of a child at risk;
- generating ideas on how to interact with a student;
- delineating a referral chain within the school building of staff who would be available to help;
- familiarizing faculty with community resources which could be used when school staff are not available;
- imparting knowledge of basic crisis intervention theory.

Emphasis was placed on the need to err on the side of caution and to take indications of possible suicidal behavior as serious. Inservice work was done by the school social worker and psychologist in partnership with experts in the community. These sessions were instrumental in building feelings of confidence and trust among the teaching staff and the social worker and psychologist.

The parent advisory committee edited pre- and post-inservice survey materials from the Cherry Creek, Colorado, Suicide Prevention Program to be used as inservice tools. The pre-inservice survey established a cognitive map for the program, and the post-inservice survey measured the impact of the inservice on faculty.

After previewing several films, "But Jack Was a Good Driver" (McGraw-Hill, 1974) was selected by the committee. It is short, elicits an emotional response, and teaches warning signs and the importance of comparing notes. It depicts two young men discovering that they might have been able to prevent the death of their friend if they had talked with each other about their observations of his behavior.

Pre-Inservice Survey

Teenage Suicide and Depression

The following survey has been compiled from information presented in a workshop on Teenage Suicide and Depression developed by the Cherry Creek School District, Cherry Creek, Colorado.

The committee from Cedarburg High School responsible for your inservice on November 12 and 13 requests that you complete this survey as quickly and honestly as you can. Some of the questions regard fact/myth and some involve personal feelings. There are no absolute, right or wrong answers.

Completed forms are to be returned to the high school office before you leave on Friday, November 9.

Section One

Please circle True (T) or False (F) for each of the following questions.

1. T F Drug and alcohol abuse are major causes of suicide.

2. T F The grieving process of survivors of a suicide is the same as that for survivors of a death by natural causes or by accident.

3. T F It is best to confront a suicidal person directly.

4. T F Most suicidal people are mentally ill.

5. T F People who talk about killing themselves are unlikely to commit suicide.

6. T F It is more difficult to identify depression in children than in adults.

Section Two

Please respond to each of the following statements by **circling the value** which best represents the degree to which you agree with the statement. The scale for each item ranges from absolute unequivocal agreement to absolute unequivocal disagreement. In order to circle either of the ends of the scale you must agree or disagree with the statement, without question, 100 percent of the time.

7. As a school employee, I feel morally obligated to prevent student suicide.

unequivocally agree 1 2 3 4 5 6 7 8 9 10 unequivocally disagree

8. Students have the right to choose to die by suicide.

unequivocally agree 1 2 3 4 5 6 7 8 9 10 unequivocally disagree

9. As a member of society, it is my responsibility to try to prevent all suicide.

unequivocally agree 1 2 3 4 5 6 7 8 9 10 unequivocally disagree

Section Three

10. Do you feel that you have a working knowledge of the causes of adolescent suicide?

Yes ☐ No ☐

11. Would you know when an adolescent is displaying suicidal symptoms?

Yes ☐ No ☐

12. If you felt that an adolescent were suicidal, would you know the appropriate referral sources in the Cedarburg area?

Yes ☐ No ☐

13. Is it true that the adolescent who talks about committing suicide will actually do it?

Yes ☐ No ☐

Section Four

Consider This Situation

A student has brought attention to him/herself because of inappropriate classroom behavior. During the course of your talk with the student he/she gives clear indication of contemplating suicide.

The initial feelings experienced in this situation by most people are personal and not necessarily professional. Whereas professional/clinical reactions may be judged "good" or "bad" and are based on experience, personal feelings are involuntary and should not be judged as "good" or "bad." After considering the situation described above, answer the following statements based on how you personally would react.

14. The fear that the student is contemplating suicide is foremost in your mind. List in the space below the **most crucial** questions you would ask and/or statements you would make during what is now a *CRISIS SITUATION*.

15. Indicate by circling a value how confident you are that the questions/statements you have listed are **the best** for this situation.

Not at all Confident	1	2	3	4	5	6	7	8	9	10	Extremely Confident

16. As a result of your talk, the student in question should be referred to the appropriate school resource person. What follow-up actions should you take at school? *(list below)*

Thank you very much for your cooperation in this extremely important matter. If you have any comments please use the back of this page.

Staff Inservice Announcement/Large Group

Cedarburg School District
Adolescent Suicide and Depression Inservice

November 12
3:30 - 4:30 p.m.

Introduction Purpose of inservice Overview of program	Jerry Thomas	5 minutes
Film "But Jack was a Good Driver"		15 minutes
Presentation – Incidence Factors – Emotional Dynamics	Marlene Cory	15 minutes
Presentation – Warning Signs – Interventions	Jacquie Sellin	10 minutes
Presentation – Comments by a surviving parent	Janet T.	5 minutes
Conclusion	Jerry Thomas	

Handouts
Teacher brochure
"Happiness is . . . The American Dream — Is it Really the American Fairy-Tale?"
Darold A. Treffert, M.D.

November 13
11:15 a.m. - 12:15 a.m.

Presentation – Adolescent Depression and Suicide	Dr. Anthony Meyer	60 minutes

Staff Inservice Handout/Large Group

Clinical Depression: Some Signs and Symptoms

Disturbances of Mood and Thought

- Prevailing sadness, the "blues"
- Feeling of hopelessness
- Feeling of helplessness
- Inability to experience pleasure
- Self-blaming, guilt (may be of delusional proportions)
- Sense of worthlessness

Disturbances of Physical Behavior or Attitude

- Slowed-down speech and body movements
- Loss of or increase in appetite
- Unusual weight loss when not dieting
- Sleeping problems (too much or too little)
- Constipation
- Loss of boyfriend or girlfriend
- Headache, dizziness, blurred vision
- Breathing problems
- Feeling of physical and psychological exhaustion, easily fatigued without really any activity
- Agitated depression may occur
- Inability to sit still
- Pacing
- Hand wringing
- Pulling or rubbing of hair, skin, clothing
- Apathy, loss of interest in appearance/activities
- Slumps, walks slowly
- Social withdrawal

Faculty Inservice/ Small Group

Faculty members were required to attend an additional inservice which was provided in a small group setting consisting of four to ten members each. In this format the topic was handled on a personal level which required some emotional investment and exploration of feelings. The session opened with a short lecture and distribution of written materials on crisis intervention. Copies of actual suicide letters were given to groups of two and three to read and discuss. A case example was shared and used to demonstrate the correct way to handle a situation.

After the completion of inservice for the administrative and teaching staff, similar sessions were held for teacher aides, library personnel, secretaries, coaches, and other key staff members who have contact with students.

■ Sample

Cedarburg High School

Memo

To: Cedarburg High School Staff

From: Jacquie Sellin, School Social Worker
Marlene Cory, School Psychologist
Al Pearson, Counseling Center, Ozaukee County

Re: Suicide Prevention Inservice

Date: January 9

This is to remind you of the small group inservice on teenage depression and suicide which will be held January 14 and February 1 in the IMC. During this inservice we hope to bring to a personal level much of the information presented at the large group inservice in December. We will discuss "what to do" in crisis intervention, and you will receive copies of outlines and strategies that should be helpful to you. We will also review some actual cases of attempted suicide, and you will have an opportunity to share your reactions with other staff members.

Teachers who have not been previously scheduled to attend this inservice are asked to attend during one of the designated time periods:

January 14	8:00 a.m. 9:50 a.m. 12:00 p.m.
February 1	9:50 a.m. 10:45 a.m. 1:50 p.m.

—or from 2:45 to 3:30 p.m. on either of those days.

Staff Inservice Handout/Small Group

Brief Thoughts on Crisis Intervention Theory

Mental Health Equation

STRESS + ENVIRONMENT + HEREDITY = ABILITY TO COPE OR NOT

Crisis implies a state of being that cannot be tolerated indefinitely. Crises are time limited. The resolution of any crisis is reached by a decision toward some action. Without some decision, the crisis will not be resolved.

Crisis Components

Precipitating Event:	Every person, every family, every relationship has its normal "level" of functioning, be that good, bad, stable, unstable. When the person, family, relationship comes up against something - **a precipitating event** - with which it cannot cope, a crisis occurs. If resources are mobilized which can resolve the situation, the crisis passes.
Disorganization:	The resources did not work. Feelings of discomfort and anxiety increase as tension increases. People turn to secondary resources, that is, persons less well known, but potentially helpful (neighbor, bartender, cabby, minister). If these fail, they turn to tertiary resources — hotlines, police departments, emergency rooms.
The Breaking Point:	When hotlines, police, and such others are called, the conflict has reached the breaking point. The persons involved are frequently at the "end of the line" and tension-filled. Suicide most frequently occurs at this point.
Reorganization:	Proper intervention provides the beginning of crisis resolution. It focuses upon the feelings of the **present** and the events of the **very recent** past. It is concerned with feelings, relationships, resources, and events which triggered the crisis **now**. Intervention helps the persons sort out and understand their feelings and gain control - at least emotional control. Once emotional control is regained the persons are ready to explore alternatives to resolve the real problem. The persons involved need to draw upon their own strengths for problem solving.
Restoration:	In this stage the persons are restored to their normal level of functioning and experience "stability" again.

Developed by T. Allan Pearson, MSW

Steps in Problem Solving

1. **Define the Problem**

   This is the most critical phase. Much problem solving breaks down here. Many persons move on too soon, without a clear definition of the problem.

2. **Generate Possible Solutions**

   Brainstorm. Get ideas from all persons involved, accept all ideas.

3. **Generate Possible Solutions**

   Consider the morality, legality, and feasibility of the solutions. Narrow solutions down to a few - sometimes less - that are "acceptable" to all sides.

4. **Decide on the Best Solution**

   This is not as hard as it may seem, especially if steps 1, 2, and 3 have been followed. Try to get consensus from all involved, while encouraging expression of feelings.

5. **Implement the Decision**

   Who does what, when, how often?

6. **Follow-up Evaluation**

   Those involved need to evaluate the decision and follow through.

Staff Inservice Handout/Small Group

Guidelines for Effective Communication

- Set a time and name the topic
- Express "I" statements
- Be very specific in your criticism and praise
- Be very specific in your request(s)
- Communicate information/feelings clearly
- Be accepting of other person's feelings
- Use active listening skills

Roadblocks

- Ordering, Directing, Commanding
- Warning, Threatening, Promising
- Moralizing, Preaching, Shoulds, Oughts
- Advising, Giving Solutions or Suggestions
- Teaching, Lecturing, Giving Logical Arguments
- Judging, Criticizing, Disagreeing, Blaming
- Praising, Agreeing
- Name Calling, Labeling, Stereotyping
- Interpreting, Analyzing, Diagnosing
- Reassuring, Sympathizing, Consoling, Supporting
- Probing, Questioning, Interrogating
- Withdrawing, Distracting, Sarcasm, Humoring

Productive Techniques

- Silence
- "Oh"
- I See
- Mm-Hmm
- How About That
- Interesting!
- Really?
- No Fooling!
- You Did, Huh?

Other Door Openers

- Tell Me About It . . . .
- Would You Like To Talk About It?
- Let's Discuss It

Staff Inservice Handout/Small Group

Case Example

It is 2:00 on Friday afternoon. A student stops you in the hall and looks very shaken. He confides in you that he is very worried about his friend. He describes the friend as being very despondent and withdrawn, especially since his girlfriend broke up with him a week ago. Today his friend told him he thought he would put an end to his misery over the weekend. In art class he made a clay sculpture of a casket and he etched his name on it. The student asks you what he should do to help his friend.

Groups should determine:

1. Issues to clarify before seeing student at risk.

2. Interview strategy.

3. Follow-up steps to take.

Parent Education

Parent education is an important link in the prevention process. Parents can be a valuable resource for getting help for their children and friends of their children. Cedarburg's committee wanted parents to know how to recognize a student at risk. It also wanted them to know that the school is able to respond to these students in a helpful way.

The parent advisory council planned an evening orientation program for parents. The program consisted of a lecture followed by small group discussions facilitated by members of the suicide committee. Much interest and concern were expressed within the small groups. The question and answer process seemed to fill an urgent need for some of the parents who attended. Some student referrals were made that evening, and additional referrals were received during the following week.

The parents who were present seemed to be those who had specific concerns and a real need for information and support.

Reading materials and a parent brochure were given as handouts. Many parents took extra copies for friends not in attendance.

Sample

Parent Workshop on Teenage Depression and Suicide

Monday, February 4, 1985

High School Commons

7:30 P.M.

* * * * * *

Main Speaker: T. Allan Pearson, MSW
Program Coordinator
Mental Health Services and Alcohol
and Other Drug Abuse Services

Small Group Question-and-Answer Session to Follow

(This session will be led by members of the Cedarburg High School Committee on Teenage Depression and Suicide.)

* * * * * *

Sponsored by the Cedarburg High School
Parent Advisory Council

Refreshments will be served

Parent Inservice Handout

Myths and Warning Signs Related to Suicide

Myths and Facts

Myth: People who talk about suicide never actually do it.
Fact: Almost everyone who attempts suicide has given some kind of warning sign or clue. When someone talks about committing suicide, he/she may be giving a warning that should not be ignored by others who hear such comments.

Myth: Talking to individuals about their suicidal feelings will give them the idea or cause them to attempt suicide.
Fact: Asking individuals about their suicidal feelings may, in fact, make them feel relieved that someone finally recognized their emotional pain.

Myth: People who try to kill themselves must be "insane" or mentally ill.
Fact: Most suicidal people are not mentally ill or "insane." They may be – and usually are – upset, depressed, frustrated, overwhelmed with despair, but not necessarily mentally ill.

Myth: The suicidal act is a typical, well thought out expression of an attempt to cope with serious personal problems.
Fact: Most suicidal persons are "irrational" at the time of their suicidal crisis; they have very strong ambivalent feelings; they want to live, but overwhelmed with despair, anxiety, and hopelessness; they cannot see any other solution to this problem.

Myth: If someone wants to commit suicide, there is usually no way to prevent it.
Fact: As noted above, **most** suicidal persons are ambivalent. Most do not want death – they want to end the pain (both physical and psychological) that they feel. They may be miserable, but they wish to be saved.

Myth: People who have tried suicide and did not "succeed," are less likely to try again because they have "gotten it out of their system."
Fact: Eighty percent of persons who die by suicide have made at least one previous attempt.

Warning Signs

Please note, not all persons show all the warning signs that follow. Some show, or seem to show, few or none. Most persons contemplating suicide feel unable to cope with whatever is troubling them – they feel helpless, hapless, and hopeless. They need your help.

- Depressed mood, pervasive sadness
- Previous suicide attempts or gestures
- Talking or writing about suicide and/or ending one's life
- Sudden withdrawal from social contacts, interests, activities
- Recent loss of a loved one or even a pet
- Sense of failure; feelings of shame or guilt
- Significant decline in, or neglect of, work or (with children) school work, frequently coupled with expressions of helplessness and apathy
- Frequent references to death and dying; decline in fear of death; listening to mournful records
- Purchase of the means of suicide; e.g., pills, rope, weapons
- Changes in eating and sleeping patterns, e.g., insomnia, increased sleeping, loss of appetite, or overeating
- Sudden mood changes or significant behavioral changes
- Family disruptions such as divorce or other changes
- Marked self-abuse through alcohol and/or other drug use
- Giving away one's personal possessions; packing one's belongings
- Self-mutilation or attempts to hurt oneself physically
- A sudden lifting of sadness, depression, or withdrawal which may indicate that the decision to commit suicide has been made

Parent Inservice Handout

How to Help the Suicidal Individual

Use active listening techniques to assess what is happening.

- Listen to the feelings being expressed; try to understand what the person is saying/ feeling.
- Focus particularly on the present and the recent past.
- Look especially for depression, agitation, or anger.

Try to assess how the person is coping with the situation and his/her feelings.

- Has depression affected behavior?
- Does the person use words like "intolerable" or "can't stand it anymore"?
- Is there a support system available for the person? Family? Friends?

Try to assess how perturbed the person is.

- Greater perturbance = greater risk of suicide.

Ask direct questions about suicide.

- Have you thought about it?
- Have you ever attempted it before?
- Have you made any plans? (*Remember:* the more detailed the plans, the greater the risk.)
- Look for constricted thinking in person's answers ("It's the only thing I can do." "It's the only way out for me.").

Take seriously all threats of suicide.

- Do they have plans for tomorrow, next week, next month?
- What are the actions considered and outcome expected?

Pay attention to YOUR gut interpretation of the situation. REMEMBER: High Perturbance + High Lethality + High Risk Factors = High Risk Suicide Risk.

- The more helpless you feel, probably the more helpless they feel.

Get Help!

- If the person is in a life-threatening situation, i.e., has already attempted suicide, or is clearly about to make an attempt, call the police or ambulance.
- If you feel the person's life is not in immediate danger, try to encourage the person to seek help from a counselor, clergy, parent, teacher, friend, or hotline. Offer to accompany the person to help. Consider entering into a nonsuicide pact with the person.
- If risk seems minimal and you are able to leave the person, at least assure the person of your availability to help and try to encourage the person to seek a referral. **You** should then seek help or advice from someone regarding how to proceed.

Special Points to Remember

Isolation is the worst thing for suicidal people. Stay close and let them know you care.

If they speak of being depressed, pursue feelings and encourage them to get help. **Depression is treatable.**

If they talk of wanting to die, don't be afraid to discuss it. **Don't consider this a taboo subject.** Offer suggestions about alternative ways of coping with the problem. Ask about specific suicide plans; remember, the more detailed and specific a plan is, the greater the risk.

Don't engage in philosophical discussions/disagreements or offer false assurances, such as "I'm sure she'll take you back." Don't make statements such as, "You shouldn't feel that way" or "Why don't you just snap out of it." It's not that simple.

Do take a suicide threat as a **cry for help.** If the individual did not want your help, you would not have been made aware of the situation.

Remove from the immediate scene any items such as pills or a gun which might be used to commit suicide.

Student Education

Finding an effective way to reach the students was the most difficult task of the Cedarburg committee. Being well aware that adolescents resist discussing intimate problems with adults led the committee to evolve the concept of *shared responsibility*. It was decided that all students should be given training in understanding the emotional dynamics of depression and suicide. They needed to be taught that suicide is preventable and that a knowledge of warning signs will help them know when they need to seek guidance for themselves or a close friend. Further, it was important for students to understand that a promise to keep a friend's plan of suicide a secret is a deadly promise.

As with the faculty inservice, students met in both large and smaller groups to learn about suicide and its prevention. At the homeroom level, advisors prepared the students for a workshop to be held by class (freshman, sophomore, junior, and senior) for all students. Prior to these large meetings, students in their homerooms wrote open-ended questions they had about suicide. These questions were given to the workshop presenters and then discussed following the large group meeting back in the homeroom setting. The follow-up meetings in the homeroom also provided opportunities for further discussion by the students. Teachers were given guides to use in conducting these sessions.

The principal opened each of the large group sessions and showed the film, "But Jack Was a Good Driver." Following the film, the county mental health center director, school social worker, and psychologist talked about the seriousness of suicide, results of a local student survey, emotional dynamics, warning signs as cries for help, shared responsibility, and community resources. Students received a copy of a brochure (see pages 56-57) listing names and phone numbers of people and agencies in the community that could provide help.

Copies of handouts used for student education are included in this section.

■ Cedarburg Sample Memo

Cedarburg High School

To: Staff

Re: Student Workshop on Suicide and Depression

Date: March 6

From: Jerry Thomas

Al Pearson, Marlene Cory, and Jacquie Sellin will conduct a workshop with all of our students on the topic of suicide and depression. The main thrust of the workshop will be to promote the idea that each individual is very important as a support person for any peer in trouble.

We would like to ask each homeroom teacher to lay the groundwork for this important workshop with each of their homerooms prior to their scheduled day of meetings. By this I mean for you to ask for an attentive and serious participation by each student.

We will also ask homeroom teachers to have their students write open-ended questions prior to the workshop and to follow the workshop with discussion in their homerooms. We will provide a teacher guide for each homeroom teacher prior to the follow-up session.

Homeroom Discussion Outline

As a follow-up to the student workshop on suicide and depression, we ask that homeroom teachers conduct a discussion in their homerooms, using the suggested topics on the following list. The topics are designed to remind the students of material presented in the workshop and to give them the opportunity (1) to express their feelings about the subject of suicide and depression in general, and (2) to review the important information about referral sources in the school and community.

Suggested topics:

A. Review a set of open-ended questions for student reaction.

B. Initiate discussion about the movie. Solicit student reaction.

C. Ask how students felt about the presentation and its open discussion about depression and suicide.

D. Suggest that students discuss misconceptions and misinformation they may have had about suicide. How did the presentation help to dispel such misconceptions?

E. Can the students identify referral sources, i.e., staff referrals, peer referrals, parent referrals, self referrals? Have the class discuss the importance of them, particularly peer referrals.

F. Peer groups are often the first to recognize the symptoms of depression in one of their members. Have students discuss what they have learned from the presentation about identification of depression.

G. Have students discuss the important people in a person's life who might provide help to a potential suicide victim. What have they learned about helpful resources within the school and community?

Suicide Questions Submitted by Students

What if you had a whole bunch of problems and you just wanted to get it over with, how should you cope?

If you're in a suicide pact and your friend kills himself, should you follow through or not?

When someone tries to commit suicide and the person is your friend, would it be a good idea to keep supporting that "friend" and stay good friends with him or should you give the friend up?

Why don't people see the signs of suicide? Do people who kill themselves have serious mental problems? Are they crazy?

Why don't people try and talk to other people before they go out and actually commit suicide?

If you attempt suicide, but do not succeed, can you be punished by law? Are you then considered insane?

Do you have to be mentally ill to commit/attempt suicide, because I've known many people to attempt suicide?

If you have a friend who once tried to commit suicide how should you act towards her? Should you try not to get her upset? How could you help or prevent this from happening again?

Sometimes I feel like killing myself so that the people I liked would remember me and that the guy I liked would have felt bad for not liking me. Is this one cause of suicide?

What if you know your friend tried to commit suicide and she tells you she's going to try again because she's really depressed and doesn't know what else to do? What should you do except for talking to her because that didn't work before and why would it work again?

Sometimes the stress of your parents expecting you to do so well in school work and homework starts to put pressure on you when you do badly, especially when it gets to be report card time. Thinking of suicide is pretty common. What should one do to avoid such a sport?

What are the causes?

What if the victim was mean before, nice for about three months, and then went back to "old self" mean?

How do you know when someone is kidding about suicide or not?

If you want to commit suicide, why does someone have the right to stop you? It's your life.

How do you deal with someone who blames himself for someone else's suicide?

If you or someone did want to kill himself, how could you help him? Who could I turn to?

How can you keep yourself from being that depressed that you would want to end your life?

I have "played" with suicide once but before I got too far with it, I stopped to think if it was worth it. It wasn't. Lately I have been thinking about it more seriously every day. Can I have the suicide prevention number so I can talk to someone? I can't talk to my parents because they don't know about the previous attempt.

What should you do if you've tried it once, no one cared, and you wanted to do it again?

How are you supposed to act when your brother comes home after he's tried to commit suicide?

What do you do when a friend threatens suicide as a joke and then says, "But then again, what do I have to live for anyway?" If you list the things and they come up with reasons not to live for those things, then what do you do?

What do you do if you are considering suicide?

Does it hurt to commit suicide?

What should you do when you really want to commit suicide but you're too scared it won't work and you'll have to live with everyone knowing you tried?

What is the most painless way to kill yourself?

Is slashing wrists painful—what I mean is, if you don't die from it will there be a scar for life?

If you think they're going to commit suicide what can you do or hint without bringing up the subject?

What should you do if one of your friends threatens to kill herself?

What do you do if you want to kill yourself but you really don't?

If someone said they tried to kill himself but you think he said it for attention what should you do?

What if you have a friend who was talking about suicide and she was going to commit it? What should you do?

What could I do to help a person who has attempted suicide, failed, and appears to be wanting to try again?

Why do people commit suicide? If someone told you he were going to commit suicide and said not to tell anyone or he'd "get" you, what would/should you do?

What would you do if everything piles up on you, homework, a death, friends don't accept you? Stuff like that. I have a friend who's like that!

What are some of the alternatives to suicide?

What's the easiest way to commit suicide?

What do you do if you can't solve your problems at all, and your life is going down, what do you do?

How do you talk to your parents and try to tell them you tried or thought about it?

If someone you know talks about killing herself every time you see her, what should you say to her? Who should you tell?

What do you do if everything is really bad and you talked to a counselor and nothing seems to help? Then you still have people being mean to you?

If your friend has one parent and really doesn't have anything going for her in your opinion and her opinion, how do you convince her not to commit suicide, especially if she doesn't have a lot of friends?

Student Take-Home Pamphlet

As a reminder to teachers, parents, and students following the workshops on suicide prevention, a pamphlet summarizing myths and facts, warning signs, recommended responses, and resources within the community was distributed. Students were told to keep the pamphlet in a safe place so that they might refer to it in the future. Students received the pamphlet in a serious manner. No brochures were found littering the halls after the sessions. A copy of the student pamphlet follows. Teacher and parent pamphlets were similar in format but varied in content to meet their respective needs and responsibilities.

Whether you have felt like ending your own life or know someone who wishes to end theirs, *remember*, help is available. *Problems can be solved; suicide can be prevented.*

RESOURCES IN YOUR SCHOOL

- Counselors
- Teachers
- Psychologist/Social Worker
- Principal
- Friends

RESOURCES IN YOUR COMMUNITY

School Resources	
High School Office	377-6030
Social Worker	375-2303
Psychologist	374-2303
Community Resources	
COPE (Ozaukee Co. Hot Line)	963-0838
Comprehensive Services Counseling Center	377-6400
Ozaukee Council (On Alcohol & Other Drug Abuse)	374-1110
Hospitals	
St. Alphonsus Hospital	344-5511
St. Michael Hospital (Milw.)	263-8175
St. Mary's Hill Hospital (Milw.)	271-5555
Law Enforcement	
Cedarburg Policy Department	377-2242
Grafton Policy Department	377-2220
Ozaukee County Sheriff's Dept.	377-5820

Emergency mental health services (24 hours/day, 7 days/week) may be reached by calling the Counseling Center (8:30-5:00, M-F) or at other times by calling your local law enforcement agency (or COPE) and having them contact the "on-call" person from the Counseling Center.

* * * * * *

Information abstracted from T. Allan Pearson, Ozaukee County Counseling Center and the Cherry Creek School District, Denver, Colorado.

Adolescent Depression and Suicide

A Guide for Students

Cedarburg School District

1985

People between the ages of 12 and 18 are choosing to end their own lives. Death by suicide ranks as the third leading killer of adolescents.

Suicide by young people is needless, and *it can be prevented.* Your knowledge about this subject may help save the life of a friend, a family member, or even yourself.

MYTHS AND FACTS ABOUT SUICIDE

It is a **myth** that talking to someone about their suicidal feelings will cause them to commit suicide.

Fact: Asking someone about their suicidal feelings may make the person feel relieved that someone finally recognized their emotional pain.

It is a **myth** that all suicidal people want to die and there is nothing that can be done about it.

Fact: Most suicidal people are ambivalent, that is, part of them is saying, "I want to die" but part of them is saying, *"I want to live."*

It is a **myth** that people who talk about committing suicide never actually do it.

Fact: When someone talks about committing suicide, he/she may be giving a warning that should not be ignored by others who hear such comments.

It is a **myth** that there is a "typical" type of person who commits suicide.

Fact: The potential for suicide exists in all of us. There is no "typical" type of suicidal person.

It is a **myth** that suicide occurs without warning.

Fact: Many people, including adolescents, give warnings of their suicidal intent.

The suicidal person feels a tremendous sense of loneliness, isolation, helplessness, and hopelessness. For the young person these feelings may be caused by family conflicts, a divorce or separation, the death of a parent, the break-up of a romance, the move to a new school, or pressure to succeed at school.

Suicidal people feel that they can no longer cope with their problems and that suicide may be the only way out. Most people *think* about suicide at some point in their life. Most people find that these thoughts are temporary and that things do get better. *Suicide is a needless and permanent solution to short-term problems.*

SOME SIGNS OF SUICIDE

Often people who are contemplating ending their lives will give signs or signals of their intent. One sign alone does not mean that a person is suicidal. Several signs at one time, however, may mean that the person is seeking help. A few of these signs include the following:

- Verbal suicide threats
- Previous suicide attempts
- Personality changes (unusual withdrawal, aggression, moodiness)
- Depression (changes in normal appetite, sleep disturbances, sudden drop in school performance)
- Final arrangements (making a will, giving away prized possessions)

When you suspect that a friend or a family member may be suicidal, you may become nervous and anxious. This is a normal feeling. It may help if you remember the following:

1) **Believe** or trust your suspicions that the person may be self-destructive.
2) **Communicate** your concern for the well-being of the person. Be an active listener and show your support.
3) **Be direct**. Talk openly and freely and ask direct questions about the person's intentions. Try to determine if the person has a plan for suicide (how, where, when). The more detailed the plan, the greater the risk.
4) **Get professional help**. Encourage the person to seek help from a school counselor, minister, or someone who can help solve the problems. If the person resists, you may have to get the necessary help for him/her.

WHAT NOT TO DO

1) Do not allow yourself to be sworn to secrecy by the suicidal person. You may lose a friendship but you may save a life.
2) Do not leave the person alone if you believe the risk for suicide is immediate.
3) Do not act shocked at what the person tells you.
4) Do not counsel the person yourself.
5) Do not debate whether suicide is right or wrong. This may make the person feel more guilty.

Referring the Suicidal Student to Appropriate Help

The Cedarburg program established a referral chain, beginning with identification of students at risk. The school counselors and high school administrators are designated as the staff within the high school who collect information about students identified as being at risk. Referrals may come from students (requesting help for themselves or a friend), teachers, support staff, parents, or members of the community. The school psychologist, nurse, and social worker may also take direct referrals or may be called in to consult on a case during this phase. Usually, they are the staff members who continue with the assessment of the referral.

Direct intervention with a student thought to be at risk for suicide usually begins with either the social worker or psychologist interviewing the student. During the interview an assessment is made and a treatment plan is negotiated with the student. Using a family systems model, parents are involved in an interview with the student as soon as possible.

Experience has shown that often a suicidal teenager may signal the existence of other troubled family members. There may be more than one depressed person in a family. Helping the family open up communication about the problem and enabling the parents to understand some of the emotional needs of their child may also lead toward helping them identify their own feelings. Often this has led to successful referrals for family therapy.

School staff should not take on the responsibility of treating a suicidal teen. However, after a referral for treatment has been made to a community agency or mental health professional, the staff functions in a supportive way and may often coordinate their work in the school setting with the student's therapist.

At Cedarburg, all staff receive training in handling a student who is at immediate risk, and high school administrators are prepared to obtain emergency services. The availability of community resources to handle crises is discussed with students and staff. In addition, all receive copies of a brochure (see pages 56-57) listing names and telephone numbers of people to contact for help.

Dealing with Loss

Student support groups are still another part of the Cedarburg program. This part began during the initial planning stages of the prevention program when the school psychologist and social worker became aware of a group of students still troubled by the suicidal death of a friend. Through word of mouth a nucleus of friends were contacted and invited to attend a group counseling session. After the first meeting, the students requested another and invited other friends of the boy who died by suicide. Two additional students who had not shared the friendship of the boy but who had lost other close friends to suicide joined the group. Meetings continued in a relatively unstructured way for approximately six sessions with students attending as they felt the need.

The film, "But Jack Was a Good Driver," was used to stimulate the beginning session. The group discussion followed a natural progression, including the expression of denial, hurt, anger, recounting of last moments, guilt, reverence for the lost individual, remembrance of happy events and special qualities of the boy, discussion of keepsakes, and the significance of the friend's life to their lives.

The group progressed to discussing various elements of frustration and stress in their lives and their difficulties in handling parent expectations. A few of the boy's closest friends were seen individually to help them explore their feelings that they, too, might be feeling suicidal and their fears that they might also kill themselves. The parents of the boy who had died were contacted about the group and lent their support. The brother of the boy attended a few of the sessions. Parents of ongoing group members were informed of the group through a letter (see p. 60).

Suicide Prevention in the Curriculum

The initial suicide prevention activities reached all of the students in the high school. The next year, a week-long course in adolescent depression and suicide was incorporated into the required freshman health curriculum within a larger unit on mental health. The school social worker and psychologist worked closely with the freshman health teacher in developing the curriculum.

In the class, suicide is discussed as a kind of life crisis rather than a form of mental illness. A film is shown to point out warning signs and stress shared responsibility. Students learn about depression and how it is treated.

The school social worker and school psychologist meet with the students on the final day of the unit to respond to their written questions. The classes are divided into two small groups to allow for student participation, including the discussion of a case example. All students receive a pamphlet on adolescent suicide and depression (see pages 56-57).

Student Survey

Of particular interest to the students has been a survey of students about suicide. The survey was begun by the director of the county mental health center when he talked with Cedarburg students about suicide in 1982. The survey was repeated at a neighboring high school in 1984. In 1985, a Cedarburg student replicated the survey for a research report and added another question of her own.

The student conducted the survey among her schoolmates. Over 50 percent of Cedarburg's high school students gave a positive response to questions 1 through 3, and approximately 40 percent responded yes to question 4. On question 5, 26 percent of the senior class answered yes, with the other classes having a lower percentage of yes responses. The senior class lost a classmate to suicide two years ago. The sixth question was answered negatively by 9 percent of the students. This response indicates, in part, the elusiveness of the problem of suicide prevention.

Sharing the survey results in class helped demonstrate to the students the immediacy of the problem. They learned that having suicidal thoughts is common within their age group. The hope is that this knowledge will allow a suicidal student to feel more comfortable seeking help.

Student Survey

1. Have you ever felt life was not worthwhile?
2. Have you ever thought about suicide?
3. Have any of your friends disclosed to you that they had thought about suicide?
4. Has anyone you have personally known attempted suicide?
5. Have you personally known anyone who has committed suicide?

Added Question

6. Do you have someone (friend, counselor, parent, teacher, etc.) to talk to if you are thinking about suicide?

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■ **Cedarburg Sample**

Letter to Parents of Suicide Discussion Group Participants

December 19

Dear

This fall, we became aware of several students who were continuing to express concerns about the loss of their classmate by suicide last year. To help them adjust to this, we invited a group of them to discuss their feelings. Following this, some students requested additional meetings. At this point, a small group has developed which the students wish to continue for at least four more sessions. The group plans to meet on Wednesdays after school. The confidentiality of these sessions is to be respected by all participants. For this reason, any conferences we may have with you will include your child's participation. The students understand that if concerns for their health and safety arise, these will be brought to your immediate attention.

We hope that you will feel comfortable allowing your child to continue participating.

Sincerely,

Marlene Cory
School Psychologist

Jacqueline Sellin
School Social Worker

La Crosse: An Expanded Student Assistance Program

6

Overview

The La Crosse school district's youth suicide prevention program has two unique features. It uses a school board-approved course as a support group for selected students, and it uses the existing student assistance program as the basis for helping suicidal students. The expanded use of the student assistance program is consistent with one of the cornerstones of the Wisconsin youth suicide prevention effort, that is, as much as possible, to use existing structures rather than to create new ones.

The program has been in existence for a number of years and began with La Crosse's hospitals expressing an interest in helping establish both an alcohol and other drug abuse and a suicide prevention effort. Their involvement reduced the level of participation which would ordinarily be characteristic of the mental health agency or the county social service department.

In an effort toward earlier identification and referral of troubled youth, the La Crosse Student Assistance Program was designed to help those students who simply "fall through the cracks" due to alcohol or other drug abuse, depression, or problems of a family, personal, or academic nature. La Crosse school district policy states that teachers are expected to refer students who have school performance problems.

Parents can refer a child by contacting the child's guidance counselor or principal, and students are encouraged to self-refer. All referrals are confidential.

A teacher who makes a referral completes a checklist of observable behaviors relating to grades, attendance, behavior, and appearance. The referral card goes to student services personnel (school counselor, social worker, psychologist, and other members of the pupil services team). The student is screened, and an appropriate in-school or community referral is made.

In-school options include individual counseling, tutoring, exceptional education assessment, and support groups around alcohol and other drug problems, divorce, or depression. Out-of-school referrals might include Teen Health Service, Coulee Council on Alcoholism, La Crosse County Protective Services, and Family and Children Center.

The Student Assistance Program requires mobilizing all available resources, advertising them, and making them readily accessible to all students and their families.

Program materials, including policies, the referral form and chart, information for staff, course outline, and letter to parents of students assigned to the contemporary problems class, begin on the next page.

Student Assistance Program Policy Statement

The School District of La Crosse recognizes that students can experience a number of personal, behavioral, or medical problems which can have an adverse effect on their behavior, conduct, or academic performance in school. Such problems could include learning disabilities, physical illness or problems, emotional and psychological problems, family or legal problems, and alcohol and other drug abuse problems. The school becomes concerned when any of these problems, which may involve a student or family member, repeatedly and definitely interferes with a student's school performance, or jeopardizes the health, safety, welfare, educational opportunity, or rights of other students or personnel.

Therefore, the School District of La Crosse establishes a Student Assistance Program to handle problems arising from behavioral/medical problems, including alcohol and other drug abuse, to function within the following guidelines:

1. The responsibility to maintain satisfactory or acceptable levels of academic performance and general conduct remains with the student at all times, whether in school, at school-sponsored events, or on school grounds. When school performance falls below satisfactory or acceptable levels, the student may be given the choice of improving conduct or performance, accepting the appropriate disciplinary action, or accepting referral to the staff resources of Student Assistance (SA) Program.

2. Students may be referred to the SA Program by any staff member or employee who is aware of a student who exhibits a pattern of definite and repeated unacceptable or unsatisfactory performance, who violates a school rule, or state or federal statute, or who manifests any signs, symptoms, or indications of the presence of a behavioral/medical problem.

3. The Student Assistance Program staff resources will attempt, by consulting with the student, to arrive at the probable cause of the performance or behavior problem. They may not counsel, provide, or otherwise treat the student in the absence of a professional diagnosis and evaluation. They may, however, recommend referral to the appropriate source of care, in consultation with the Student Assistance Program coordinator, the principal, the student, and his/her parent or guardian.

4. At all times it is the prerogative of the student to *accept* referral to the SA Program staff or to professional assistance, or to *reject* it. If a student accepts or rejects assistance, it still remains his/her responsibility to bring performance up to satisfactory or acceptable levels, or to face such disciplinary action as may be warranted. Professional assessment may be required by the principal as a condition of continuing in the normal school program.

5. If a student accepts referral and treatment, the fact will be regarded as it would for any illness, with respect to benefits or privileges. So long as a student is involved with the SA Program, and is cooperatively and/or successfully addressing his/her problem, the student may remain in school and continue with normal activities and privileges.

6. No records of a student's involvement with the SA Program are to be kept in his/her personal file. What minimal records must be kept are to be considered of a medical

nature and will be maintained separately. No records of conversations a student may have with a member of the SA Program staff will ever become part of the student's personal file or cumulative record. The fact of a student's participation in the SA Program, in addition to specifics, will remain absolutely confidential, and subject to state or federal regulations governing confidentiality and the release of information.

7. An essential feature of the Student Assistance Program is that students who think they have a behavioral/medical problem, including alcohol and other drug abuse, may contact the SA Program staff resources voluntarily, with the same assurance of confidentiality.

8. The School District of La Crosse also recognizes that a student can be adversely affected by the stress resulting from a family member with a behavioral/medical or personal problem, including alcohol and other drug abuse. Therefore, help under the SA Program is extended to all students and their immediate family members, at either's request.

9. The awareness and support of parents for a student with a behavioral/medical or personal problem is extremely important. However, should either students or parents/guardians not wish to cooperate in improving school performance, or in making assistance available, the student's status in school will be re-evaluated, taking into consideration the best interests of the student, the nature of the problem, and the health, safety, welfare, educational opportunity, and rights of other students or personnel.

10. It is against school policy for anyone—students or staff—to be in school, on school grounds, or at school-sponsored activities under the influence of alcohol or other drugs. Federal and state laws also proscribe the possession, use, sale, or delivery of alcoholic beverages and controlled substances. The School District of La Crosse recognizes its responsibility to inform and involve the appropriate law enforcement officials of violations when it appears to be in the best interests of all concerned, and/or when other attempts to assist the student have failed.

11. Prescription medications are construed as exceptions to this policy when used by the individual for whom they are prescribed and in the manner prescribed.

12. It is the responsibility of each building administrator and/or designee to use procedures consistent with this policy. Nothing in this policy is intended to result in any special regulations or exceptions from standard administrative practices regarding student discipline.

Student Health Policy on Chemical Dependency

The School District of La Crosse recognizes that chemical dependency is an illness often preceded by misuse and abuse that can be prevented or treated. The concern over chemical abuse is directed at the effects it has on student performance in school, as well as its effects on adolescent growth. Therefore, the School District wishes to intervene early in the illness process by contacting students showing signs of chemical abuse to assist them should they need help.

The La Crosse School District also believes that, along with parents and other segments of the community, the school has a role to play in helping students to make responsible decisions about the use of alcohol and drugs. Therefore, the District wishes to cooperate with all segments of the community in making the means of assistance available to those individuals who develop alcohol and other drug-related disabilities.

In keeping with this philosophy, the following program guidelines are being established.

1. It should be understood by parents, students, and staff that school rules and regulations or state and federal laws will be enforced by school officials. The students' rights and responsibilities, as outlined by the Student Conduct Code, will be adhered to as the standard administrative practice regarding student discipline and students' rights.

2. The main responsibility for operating the program will be in the hands of each building principal (or designee) who will interpret the District's policy to students, staff, parents, and the community, and a resource person, who will assess the nature and scope of alcohol and drug problems in students referred, and make recommendations for the appropriate form of assistance.

3. An essential feature of the program is that students, along with families, are encouraged to contact staff persons, the building principal, or the resource person regarding problems with alcohol and other drugs, with the assurance that such contacts will be handled confidentially (in accordance with all state and federal laws).

4. Students may be referred to the resource person by school staff, other students, parents, or community agencies (i.e., clergy, law enforcement, etc.). Staff members will be expected to refer any student who:

    a. Exhibits a definite and repeated pattern of decline in their school performance, which may be alcohol or drug-related, and

    b. Manifests any signs, symptoms, or indications of a chemical problem.

The District believes that if a student is involved in the Chemical Dependency Program and successfully addressing harmful involvement with chemicals, he/she should be encouraged to continue in the regular school setting and in any special programs, i.e., special education, work study.

APPROVED BY THE BOARD OF EDUCATION September 8, 1981

La Crosse Sample ■

Referral Form

Student Assistance Program

If a troubled student is to be helped, he or she should be referred to one of the counselors. Such referrals must be based on behavior which you have actually observed. As a rule, isolated instances of poor or unsatisfactory performance will not be grounds for referring the student. However, whenever the student exhibits several of the following, or there is a definite and repeated pattern or tendency in an unacceptable direction, he or she should be referred.

Student ______________________________ Grade _____ Date ________________

Referred by ____

Please Check Appropriate Responses:

I. *Academic Performance Observed:*
- ☐ Declining quality of work
- ☐ Declining grades earned
- ☐ Incomplete work
- ☐ Work not handed in
- ☐ Academic failure

II. *Classroom Conduct Observed:*
- ☐ Disruptive in class
- ☐ Inattentiveness
- ☐ Lack of concentration
- ☐ Lack of motivation
- ☐ Sleeping in class
- ☐ Failing memory
- ☐ Extreme negativism
- ☐ In-school absenteeism (cutting)
- ☐ Tardiness to class
- ☐ Defiance; breaking rules
- ☐ Frequently needs discipline
- ☐ Cheating
- ☐ Fighting in class
- ☐ Throwing objects
- ☐ Defiance of authority
- ☐ Verbal abuse
- ☐ Obscene language, gestures
- ☐ Sudden outbursts of temper
- ☐ Vandalism
- ☐ Frequent visits to lavatory
- ☐ Hyperactivity, nervousness

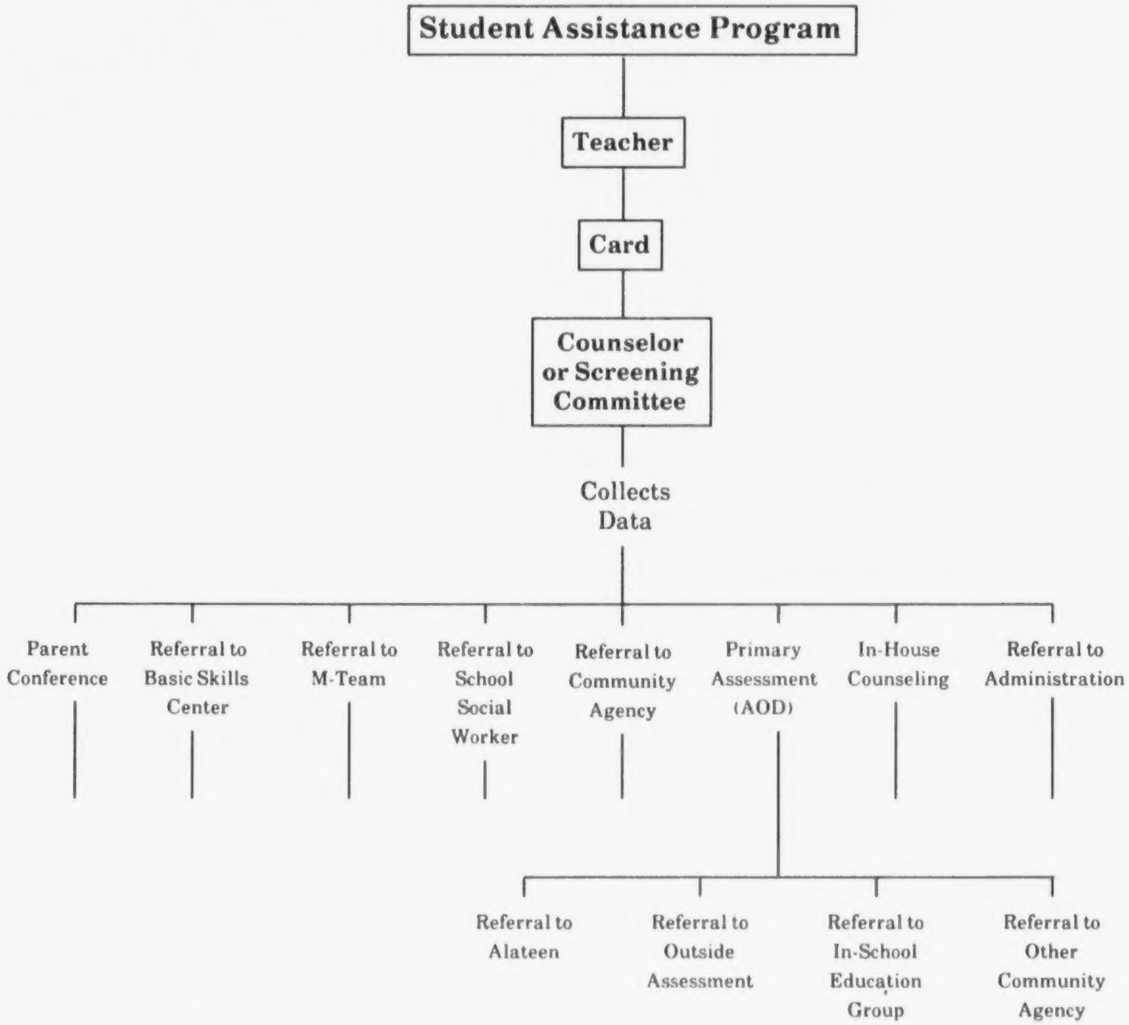
III. *Other Unusual Behavior Observed:*
- ☐ Erratic behavior from day-to-day
- ☐ Negative change in friends, peer group
- ☐ Older social group
- ☐ Sudden, unexpected popularity
- ☐ Mood swings
- ☐ Seeks constant adult contact
- ☐ Public intimacy; sexual looseness
- ☐ Seeks adult advice without a specific problem
- ☐ Time disorientation
- ☐ Unrealistic goals
- ☐ Changes in personal values
- ☐ Inappropriate responses
- ☐ Depression
- ☐ Defensiveness
- ☐ Withdrawal; a loner
- ☐ Other students express concern about possible problem
- ☐ Fantasizing, daydreaming
- ☐ Struggle for achievement
- ☐ Difficulty in accepting mistakes
- ☐ Being rigidly obedient

IV. *Possible Alcohol/Drug Behaviors:*

Witnessed	Suspected	
☐	☐	Selling, delivering alcohol, drugs
☐	☐	Possession of alcohol and drugs
☐	☐	Possession of drug paraphernalia
☐	☐	Use of alcohol, drugs
☐	☐	Under influence of alcohol, drugs
☐	☐	Odor of alcohol, drugs
☐	☐	Talks freely about use
☐	☐	Associates with known users
☐	☐	Physical signs

V. *Other School Conduct (to be completed by Counselor):*
- ☐ Unexcused absences
- ☐ Frequent absenteeism (excused)
- ☐ Marked absent but in school
- ☐ Tardiness
- ☐ Suspensions
- ☐ Schedule changes
- ☐ Frequent disciplinary referrals
- ☐ Loss of athletic eligibility
- ☐ Increasing non-involvement
- ☐ Involvement in thefts, assaults
- ☐ Carrying weapons
- ☐ Home problems
- ☐ Job problems
- ☐ Problems with law enforcement

Chart Referral


Student Assistance Program
Teacher
Card
Counselor or Screening Committee
Collects Data
Parent Conference
Referral to Basic Skills Center
Referral to M-Team
Referral to School Social Worker
Referral to Community Agency
Primary Assessment (AOD)
In-House Counseling
Referral to Administration
Referral to Alateen
Referral to Outside Assessment
Referral to In-School Education Group
Referral to Other Community Agency

Student Assistance Program

Goal:

1. To recognize performance problems
2. To make it possible for the student to see the effects of the performance problems
3. To provide the opportunity and support for his/her efforts to eliminate the performance problem

What: A system designed to identify students as needing assistance based on *school performance*

Why: To deal with student problems in a more effective and consistent manner

Who: Students who are not performing at acceptable levels in your classroom — includes attendance, behavior, attitude, and academic performance

How: Options available

1. Confront the student with the exact nature of the performance problem and require that it improve.
2. Contact parents regarding the student's performance problem.
3. Make a referral to the student's counselor by completing a referral card.
4. Where the problem is a serious or immediate one, refer to the School Administrator immediately.

Action: Once the referral has been made the appropriate counselor sees the student to discuss the nature of the performance problem, attempts to discover what the probable cause is, and presents him or her with a choice among several alternatives which would include:

1. Improve performance (on own or with available help)
2. Parent contact (phone, letter, or conference)
3. Referral to school social worker
4. M-Team
5. AOD screening
6. Contemporary problems group
7. Any of the community referral agencies
8. Closed campus
9. Suspension
10. Expulsion

Responsibility:

The responsibility for improving school performance rests with the student; however, we have to remain available to assist him/her if needed. It is our obligation to provide the opportunity and support for his/her efforts to eliminate the performance problem.

If the student and/or his parents do not agree for the need to improve performance, the student's status in school has to be re-evaluated.

Student Contemporary Problems Seminar

Course Purpose

The purpose of the Contemporary Problems Seminar is to provide education and support for youths experiencing school performance problems related to alcohol and other drug use and abuse and to encourage students to take a closer look at the effects of their use on school performance and their personal lives. The goal is to provide knowledge and support for students who need to take a closer look at themselves and the consequences of their actions.

Course Structure

This class will meet regularly once a week for the entire semester. Credit will be determined in accordance with School District Policy for course credit.

Entrance into the course will be controlled by one of the following:

- Parent referral
- Counselor referral
- Teacher referral through the counselor
- Self-referral through the counselor
- Administrative referral
  - —Through counselor initiative
  - —Positive alternative to further disciplinary action
- M-Team referral

Maximum size for the class will be no more than 15 students per instructor.

All referrals and individual personal records will be kept in confidence.

Objectives

- To develop an awareness of personal responsibilities in participating students
- To demonstrate effective decision-making processes in students' daily activities
- To foster growth of self-concept in students
- To develop an awareness of social and peer pressures in the development of social problems
- To alert students to the influence of the family in daily living
- To develop personal problem-solving skills in participating students
- To recognize the reasons for social controls and respect for the rights of others

Methods

This course involves written assignments, classroom discussion, guest speakers from the community, and audiovisual presentations.

Evaluation will be based on satisfactory achievement in the areas listed in the course objectives. This will be determined by regular attendance, classroom participation, written assignments, and tests on the material presented.

Legislative Authority

Wisconsin State Statute 115.35 established the following:

- A critical health problems education program is established in the Department of Public Instruction. The program shall be a systematic and integrated program based on scientific knowledge of the human organism as it functions within its environment and designed to favorably influence the health, understanding, attitudes, and practices of the individual child which will enable him to adapt to changing health problems of our society. The programs shall be designed to educate youth with regard to critical health problems and shall include, but not be limited to, the following topics as the basis for comprehensive education curricula in all elementary and secondary schools: controlled substances, as defined in s. 161.01 (4); alcohol; tobacco; mental health; and related health and safety topics.
- In carrying out this section, the state superintendent may, without limitation because of enumeration, do the following:
  - —establish guidelines to help school districts develop comprehensive health education programs;

- establish guidelines to help school districts develop comprehensive health education programs;
- establish special inservice programs to provide professional preparation in health education for teachers throughout the state;
- provide leadership to institutions of higher education to develop and extend curricula in health education for professional preparation in both inservice and preservice programs;
- develop cooperative programs between school districts and institutions of higher education whereby the appropriate health personnel of such institutions would be available to guide the continuing professional preparation of teachers and the development of curricula for local programs;
- assist in the development of plans and procedures for the evaluation of health education curricula.

La Crosse Sample ■

Letter to Parents of Students Assigned to Contemporary Problems Class

Date ____________ School ______________________ Phone Number _______________

Dear ______________________

Your child has been assigned to our Contemporary Problems Class which meets weekly, for one hour, during the school day. If you have any questions please call your child's principal or guidance counselor.

Thank you.

____
Principal

Whitnall Area Youth Services Program

7

Overview

The community of Whitnall has developed a unique approach to dealing with a variety of youth issues, using a community-based, school-focused approach. The community formed a committee which not only explored the needs of youth but also asked why those needs were not being met. The committee recognized that the community had the basic resources which were needed to help youth but that it was difficult to coordinate those services. Whitnall put aside historical difficulties between agencies as reasons to prevent full service delivery. Instead, the committee developed a list of objectives that they felt would resolve those difficulties and recommended that a school/community social worker be employed to help coordinate available services.

During the 1983-84 school year, the Whitnall School District suffered two tragic student suicides. These deaths caused an emotional upheaval. The community knew something needed to be done, but no one seemed to know what to do or how to go about doing it.

A group of concerned parents, municipal officials, school board members, school personnel, professionals, and clergy formed a committee called the Whitnall Area Youth Services Committee (WAYS) to pool resources and address local problems. After this committee met to discuss the problems and research the issues, it became apparent that suicide was just one of several crisis situations that needed attention. Several service needs emerged during the WAYS Committee meetings, including

- local services improvement;
- extended school social services;
- police social services;
- community mental health education;
- services to different municipalities from one common program;
- coordinated service among the schools and other municipalities.

The WAYS Committee concurred that the school district as well as the municipality had an obligation and responsibility to address these needs. Integrating services of a school/community social worker, an advisory committee, and a community-based support network emerged as a program that could be locally administered to address these needs on a year-round basis. The target population was all Whitnall School District children and their families.

The WAYS Committee now acts in an advisory capacity to the program, which has been in operation since August 1, 1985. The following goals and objectives have been successfully accomplished with the enthusiastic support of the school and community.

Goal One: Awareness

As their first goal, community residents decided they needed to have the necessary knowledge and skills to recognize, prevent, and manage mental health problems at the earliest possible stage.

This goal resulted from the perception that there was a lack of knowledge and information regarding suicide, depression, drug abuse, anxiety, child-adolescent maturation, and sexual abuse. This perception was based on the number and frequency of inquiries and referrals received by school, health, and police department personnel.

The school district and local health departments had addressed these issues on a limited basis, with not all people in need being served locally. For example, school district services were highly concentrated on public school students, but approximately 26 percent of the district's students attend private schools.

While county services were available to school district residents, including students, they were not readily available because of travel and accessibility limitations.

It was apparent that these youth issues needed to be addressed on a local basis; therefore, the committee proposed a local, jointly administered program between the school district and municipalities. The key to the effort was hiring a school/community social worker. A description of the four objectives identified for the program follows.

Objective One

To conduct community health education and prevention programs focusing on health maintenance and lifestyle practices.

In order to help community residents gather and utilize information that will benefit and improve physical and mental health, the school/community social worker will develop informational programs for community residents. These programs will stress positive aspects of good mental health and lifestyle practices, be ongoing, and provide information based on perceived student needs on topics such as stress management, family systems, and maintenance of optimal mental and physical health.

Objective Two

To establish an emotionally healthy environment for purposes of open communication among school administrators, clergy, health care professionals, municipal officials, staff (teachers), parents, and students.

The school/community social worker will work closely with each municipality, school staff, parents, local clergy, and students to promote an open dialogue regarding mental health and other social matters. Various public forums will be conducted to assess the needs of the community and the effectiveness of meeting those needs. The WAYS Advisory Committee will be made up of school representatives, municipal representatives, clergy, parents, and students who will advise regarding policy, procedure, and programs and will help develop community support for the overall program.

Objective Three

To provide health information which will assist individuals in identifying the early signs and symptoms of mental health concerns through Cable TV, the community newspaper, community bulletin boards, pamphlets, literature, and a directory of community resources.

Community resources need to help interested individuals learn more about mental health concerns, especially as they pertain to students. Up-to-date information on a variety of health concerns will be made available by the school/community social worker so that individuals may learn about important health issues, how to deal with them, and how to help recognize and prevent potential mental health problems. This dissemination of information may be done several ways, including using the local Cable TV channel and the quarterly school district newsletter.

Pamphlets and other printed materials can be distributed by the public health and police departments and schools during their regular activities. Information, including invitations to workshops and inservices, can also be posted on bulletin boards located in municipal buildings, churches, schools, and clinics.

Without the knowledge and skills to recognize mental health problems at an early stage, individuals are helpless to intervene to prevent the frequently tragic outcomes. Therefore, it is important for people to recognize early warning signals.

Objective Four

To develop and implement a consumer mental health education plan that includes

- an information and referral system for existing community resources and services;
- knowledge of consumer rights and responsibilities as related to care, counseling, and services.

The school/community social worker and the WAYS Advisory Committee will develop a long-range mental health education plan. This plan will address the local needs and set priorities, assess how and when the local needs will be met, and include an information referral system for existing community resources and services. The plan will be reviewed and evaluated annually and updated as needed.

All school district residents will receive a directory containing information on how to use various services as well as information about consumer rights and responsibilities as they relate to mental health care, counseling, and services.

The school district and health departments will conduct annual informational workshops on mental health programs covering such areas as adolescent maturation, sexual abuse, drug abuse, anxiety, depression, suicide, mental health consumer rights and responsibilities, and family losses.

Objective Five

To provide information and training to parents, guardians, and others to effectively deal with troubled young people.

Parents and guardians must have the necessary knowledge, skills, and intervention techniques to effectively deal with a wide array of child and adolescent issues. Many problems can be resolved, especially if the problem is dealt with early.

The school/community social worker will provide information and training to parents or guardians to prepare them to recognize situations that could contribute to mental health problems. Information and training sessions will stimulate public and parent awareness of problems and educate participants about the availability of services. Films, tapes, articles, books, consultants, and support groups will be used to help the community learn about, deal with, and prevent problems associated with the school-aged child's development and mental well-being.

Goal Two: Community Support Services

The second goal is to make comprehensive community support services available to the district's public and private school students and their families. Two objectives were developed to help in achieving this goal.

Objective One

To hire a school/community social worker to administer the formation of a community support service program which will include, but not be limited to, the

- coordination of support services with existing ones to expand access beyond the regular school day and calendar;
- development of a community resource directory specific to the Whitnall area;
- administration of an ongoing professional, community-based advisory committee;
- administration of an ongoing community-based, professional support network.

Access to comprehensive community support services has been a community, family, and school concern. Loosely organized and highly reactive response to recent youth suicides in the Whitnall area exacerbated the need for cooperative efforts among mental health, law enforcement, school, and municipal officials and clergy and spurred joint, interagency planning.

Clearly there was a need to integrate already existing school/community services, expand the professional base of resources within the municipalities, and initiate a systematic method for family/student crisis intervention that will extend beyond the school day and school year.

Objective Two

To develop a crisis intervention program which will include, but not be limited to

- provision of adequate training to community resource personnel in the area of crisis intervention (e.g., family violence, rape, or sudden death/suicide);
- development of standard procedures to handle crises and promulgate these among personnel;
- referrals to existing community resources and assistance in their effective use.

The school/community social worker is responsible for developing and implementing a functional, effective crisis intervention program that includes training an expansive network of professionals and paraprofessionals as well as developing the support system necessary for maintaining these professionals' contacts within the area.

Issues of crisis usually require immediate action. In order that these crisis situations can be effectively dealt with, personnel must have an organized, procedural approach so that intervention is conducted efficiently and effectively. Part of the development of this network and the evaluation of this program should include a procedural guide. The guide should include a diagnostic outline and a clear understanding of the extent of the crisis and how and when to refer.

Goal Three: Law Enforcement Involvement

Whitnall's third goal in its plan for a comprehensive suicide prevention effort is to give community law enforcement personnel access to a youth services program which allows them to intervene, regardless of municipal boundaries, when antisocial behavior--criminal or noncriminal—occurs. Three objectives have been identified to help achieve this goal.

Objectives One, Two, and Three

- *To intervene in youth problem situations where legal constraints inhibit police action*
- *To mediate severe crisis situations involving school-age;children and children as defined in s. 115.76, Wis. Stats.*
- *To provide for a systematic follow-up of referrals*

Parts of three municipalities are incorporated within the Whitnall School System: the Village of Hales Corners, the City of Franklin, and the City of Greenfield. The police are hampered by jurisdictional boundaries in noncriminal situations. Mischievous acts committed by youngsters are not always violations of the law. Acts such as gang activities, loitering, harassment, and truancy may go unchecked by police due to not being able to enforce the law. To close the gap between legally unenforceable improper juvenile action and actual criminal activity, the school district needed a mediator.

A social services professional with the ability to cross over any municipal boundary and address juvenile problems face-to-face is necessary. That person, a school/community social worker located in a neutral setting, must be able to

- give additional training to police personnel in sensitive situations;
- work side-by-side with police personnel as an additional resource;
- handle problems that occur where the police are not able to investigate because of legal restraints in noncriminal matters;
- be used by police personnel as a referral resource.

Shawano: A Youth Issues Approach

8

Overview

The Shawano program was created as a result of the increasing frustration people in the school and community agencies were feeling about youth who were having difficulty but not being helped effectively. It was clear that help was not getting to youth or that agencies were inadvertently working against each other.

The answer was to form an interagency group to deal with youth and families in need of help. The group coordinates the helping activities of all its agencies to insure that all community resources are used effectively. While this approach does not singularly represent a youth suicide prevention program, it does deal with alleviating the stresses youth encounter.

At the center of this is the intensified student program. By definition, an intensified student is someone who requires specific educational, legal, and social services. In this approach, the interagency committee decides when an individual student requires specific services. Each agency then agrees to provide those services in the most appropriate setting. Students receive a variety of educational, legal, and social services from the school and other community agencies.

Students are programmed in a manner designed to accomplish at least three things. First, they receive an educational program which meets district and state requirements for graduation. Second, they receive individual counseling from social service or mental health agencies. In cases where neglect or abuse can be shown, they also receive child protective and legal services. Third, students and their families are provided with supportive and educational services which improve the family's ability to meet physical and emotional needs. These services might include parenting classes or an aide to stay with the student after school until parents can be with their children.

The use of existing resources, the coordination of services, and the sharing of information about students' needs allow for the efficient, effective youth issues approach to serving the needs of students.

The program is a cooperative endeavor among the Shawano-Gresham School District, Department of Social Services, Family Systems/Services, Unified Health Services of Shawano and Waupaca Counties, Community Counseling Center, and the district attorney's office. A comprehensive program outline follows.

Program Outline

The Shawano approach focuses on keeping the student in an appropriate educational setting while meeting the needs of students and their families. To accomplish this, the school and the community agencies cooperate to provide a variety of programs and services.

Educationally, the student may be served on a one-to-one or small group basis. When appropriate, students remain in regular classes. The interagency group offers students and their families a variety of services. These might include family counseling, AODA counseling, individual counseling, parenting classes, or parental support groups. The value of this approach is evident in programming for students who are able to receive AODA therapy without interrupting their education. Students receiving therapy can be closely monitored while in the intensified student program to assure that they return to the traditional classroom as quickly as possible.

Agency Contributions

The primary responsibility for the intensified student program lies with the Shawano-Gresham School District, which provides a teacher to supervise the educational program located in the school. The district's director of pupil services coordinates and organizes this effort.

The County Department of Social Services provides program aides (one for each student with severe problems and/or one for each small group of students), social workers who provide services directly to families, and a representative for all intensified student program team meetings. Social services staff provide child welfare and truancy assessments as well as referrals to the court.

The Shawano County district attorney considers the recommendations of the social service department regarding disposition of juvenile cases. The district attorney can also take action to enforce court orders directing families to participate in the program. The legal follow through provides the program with the legitimacy essential to its success.

Family services staff provide intensive family therapy, attend all program team meetings, and conduct parenting classes along with the school social worker.

Unified Health Services of Shawano and Waupaca Counties provides psychological evaluation, counseling, and a staff person for team meetings. In situations where a student meets the DSM-III definition of severe mental illness, the Unified Health Board provides a program aide.

The Community Counseling Center focuses on the special needs of the AODA student. It provides AODA counseling on a one-to-one or group basis and a room where students may work with a teacher or with an adult tutor.

Program location is determined by student needs. Those who need AODA services are assigned to a Community Counseling Center site. Elementary, middle, and high school students with mild problems are served in regular public school settings. Students with severe problems are assigned to a site determined by the program team. The program requires no new appropriations and no shifting of funds between agencies. The major administrative impact is a reallocation of time for agency staff.

Student Services

Children and youth with severe problems which prevent them from functioning or being adequately served in a regular public school setting are served. Additionally, the program is designed to help children and youth who are AODA involved and students who are functioning well in the public school but who are at risk of developing severe problems.

The two groups served by the program are handled differently. Children and youth with severe problems are served away from the regular school. The school district provides a teacher to conduct classes, and the community agencies provide the aides to work with the students at the intensified program site. This site needs to be close to schools to allow easy access for those students who attend some classes in the regular setting. It is important for the site to have a private area for counseling and conferences in addition to the classroom.

Students who do not have severe problems will remain in the public school and attend normal classes. The school will, however, provide time for staff from community agencies to work with the students during the school day. The students and their families may also receive other services as directed by the program team.

Youth with AODA problems are provided with an educational program at the counseling center, a 28- to 30-day outpatient treatment program, mainstream opportunities at the public school, and a guaranteed return to the public school when they are ready.

Time Allocations

Teachers spend varying amounts of time in the program. No additional teacher time is necessary for students who remain in the regular school setting. However, students who are in either the AODA treatment or the intensified student category (i.e., in need of specific educational, legal, and social services) receive at least three additional hours of teacher time per week.

Elementary students attend classes for the state-recommended six hours daily. Middle and high school students are in class for six and one-half hours. If the program team feels after-school supervision is necessary, aides are provided until parents can be with their children.

Academic Credit

Credit approval is automatic for any student in the intensified program who attends regular classes. In other situations, such as when a student is in AODA treatment, credit is designated by the building administrator.

Students can receive credit for classes specially designed for them if the rationale, goals, and objectives of the course have been approved by the school. Approvals are based on course outlines submitted by the counseling center.

Student Referral

Referrals are made to the program coordinator by school staff, through building administrators, social services, or by any agencies involved with the student or parents.

The coordinator conducts weekly program meetings of the service team and introduces referred students to the team. The team reviews referral information to determine whether the student can be accepted for the program. If a student is not placed in the program, the team recommends specific preventative services. If the student is accepted, the team outlines the educational and special services that need to be provided and decides which agency shall offer them.

Parents must give written permission for their child to participate in the program. Once in the program, students are monitored by the teacher and the program coordinator to assure they are receiving the help needed to enhance their social, emotional, and educational development.

Teacher Responsibilities

Teachers and the service team work cooperatively to develop an educational plan for each student. This includes developing lesson plans, working with individual students, supervising program aides, and allowing time for community agencies to provide services during the school day.

Teachers who work with students receiving treatment/education at the Community Counseling Center meet with the regular teachers and school counselors frequently. They arrange to take academic work to the counseling center and return completed assignments to the school. When classwork cannot be done at the center, teachers arrange for students to attend specific classes in the regular school. Teachers also make temporary or permanent schedule changes to allow students to maintain satisfactory academic progress. The teacher makes regular reports to the program coordinator to indicate progress or problems with individual students.

Linkage to Existing Programs

Coordination and collaboration of community resources are the keys to Shawano's success. Whenever possible, the program is directly linked to programs and services currently provided in the school district/community. Links have been formed with regular education classes, special education classes, the PACE program, the ASSAP program, night school, County Extension, Family Systems/Services, AODA counseling programs, and Unified Health outpatient services.

Appendixes

9

A. Community Resources Network Sheet
B. General Community Assessment Sheet
C. Action Plan Worksheet
D. Youth Suicide Prevention Handout
E. Suicide Prevention Resource List
F. Wisconsin Department of Public Instruction Resources
G. Wisconsin Department of Health and Social Services Resources
H. Suicide Prevention Legislation
I. Suicide Prevention Bibliography

Community Resources Network Sheet

CESA

1.
2.
3.

Church

1.
2.
3.

County Social Services

1.
2.
3.

Law Enforcement

1.
2.

Medical

1.
2.

Mental Health

1.
2.
3.

Private Agency

1.
2.
3.

Private Business

1.
2.
3.
4.

Private Citizen

1.
2.
3.
4.

Public Health

1.
2.

School

1.
2.
3.

State Agency

1.
2.
3.

Students

1.
2.
3.
4.

General Community Assessment Sheet

Population

Overall ________

Males ________

Females ________

School Age ________

Males ________

Females ________

Number of youth suicides in last 3 years _____

Number of youth suicide attempts in last 3 years _____

Income

Under $10,000 ________

$10,000-25,000 ________

$25,001-49,999 ________

$50,000-over ________

Schools

Number of High Schools _____

Number of Middle Schools _____

Number of Elementary Schools _____

Major Employers

____

____

____

____

Adult Population's Education Level *(estimated)*

Less than High School ________

High School ________

Technical School ________

College ________

Graduate School ________

Potential Financial Support Resources

____

____

____

____

____

Recreational Opportunities

____

____

____

____

____

Service Agencies in Community

____

____

____

____

____

Action Plan Worksheet

DATE

Task	Person Responsible	Timeline	Cost	Cost Charge to

Appendix D

Youth Suicide Prevention Handout

This handout on youth suicide may be reproduced and used for awareness workshops for staff, community groups, or students.

Basic Information About Suicide

Why Do People Commit Suicide?

The suicidal person feels a tremendous sense of loneliness, isolation, helplessness, and hopelessness. For the young person, these feelings may be caused by family conflicts, a divorce or separation, the death of a parent, the break-up of a romance, the move to a new school, or pressure to succeed at school.

Suicidal people feel that they can no longer cope with their problems and that suicide may be the only way out. Most people **think** about suicide at some point in their life. Most people find that these thoughts are temporary and that things do get better. Suicide is a needless and permanent solution to short-term problems.

Major Life Crises of Students

- Death of a family member.
- The divorce or separation of parents.
- The adolescent's own pregnancy or illness.
- A change in residence.
- Breaking-up with one's boyfriend or girlfriend.
- Loss of family social or financial status.
- Rejection by peers.
- Failure to achieve.

Warning Signs

One sign alone does not mean that a person is suicidal. Several signs at one time, however, may mean that the person is seeking help. A few of these signs are:

- Depressed mood, pervasive sadness.
- Previous suicide attempts or gestures.
- Sudden withdrawal from social contacts, interests, activities.
- Recent loss of a loved one or even a pet.
- Sense of failure, feelings of shame, guilt.
- Significant decline in, or neglect of, school work frequently coupled with expressions of helplessness and apathy.
- Frequent references to death and dying; listening to mournful records; decline in fear of death.
- Purchase of the means of suicide; e.g., pills, rope, weapons.
- Changes in eating and sleeping patterns; e.g., insomnia, increased sleeping, loss of appetite, or overeating.
- Sudden mood changes or significant behavioral changes.
- Family disruptions such as divorce or other changes.
- Marked self-abuse through alcohol and/or other drug use.
- Giving away one's personal possessions; packing one's belongings.
- Self-mutilation or attempts to hurt oneself physically.
- A sudden lifting of sadness, depression, or withdrawal which may indicate that the decision to commit suicide has been made.
- Themes of death, depression, and suicide in art work and writing.

What To Do

When you suspect that a student may be suicidal, you may become nervous and anxious. This is a normal feeling. It may help if you remember the following:

Believe or trust your suspicions that the student may be self-destructive.

Communicate your concern for the well-being of the student. Be an active listener and show your support.

Be direct. Talk openly and freely and ask direct questions about the student's intentions. Try to determine if the student has a plan for suicide (how, where, when). The more detailed the plan, the greater the risk.

Get professional help. Encourage the student to seek help from a school counselor, minister, or someone else who can help solve the problems. If the student resists, you may have to get the necessary help for him/her.

What Not To Do

- Do not allow yourself to be sworn to secrecy by the suicidal student. You may lose the confidence of the student for a while, but you may save a life.
- Do not leave the student alone if you believe the risk for suicide is immediate.
- Do not act shocked at what the student tells you.
- Do not debate whether suicide is right or wrong. This may make the student feel more guilty.

Myths and Facts About Suicide

Myth: Talking to someone about their suicidal feelings will cause them to commit suicide.

Fact: Asking someone about their suicidal feelings may make the person feel relieved that someone finally recognized their emotional pain.

Myth: All suicidal people want to die and there is nothing that can be done about it.

Fact: Most suicidal people are ambivalent, that is, part of them is saying, "I want to die," but part of them is saying, "I want to live."

Myth: People who talk about committing suicide never actually do it.

Fact: When someone talks about committing suicide, he/she may be giving a warning that should not be ignored by others who hear such comments.

Myth: There is a "typical" type of person who commits suicide.

Fact: The potential for suicide exists in all of us. There is no "typical" type of suicidal person.

Myth: Suicide occurs without warning.

Fact: Many people, including adolescents, give warnings of their suicidal intent.

A Positive Note

People have a will to live, a will that can once again become dominant. With proper guidance or treatment, the hopelessness disappears and the potential suicide victim can be restored to full, active, and happy living. Help is available. You may be an important part of that help and a vital first link in assuring that professional assistance is obtained and that a life is saved.

Appendix E

Suicide Prevention Resource List

The following resources are a representative sample of the types of materials available for use in suicide prevention efforts. Inclusion in this appendix does not constitute an endorsement.

Audiovisual Materials

But Jack Was A Good Driver
McGraw Hill Films
Box 641
Del Mar, CA 92014

Visits the scene of a high school senior's funeral. Covers the warning signs of youth suicide and has a viewer-directed segment dealing with the facts of suicide. Color 16mm film, 14 minutes. $255.00. Also available for $11.00 rental fee through the Bureau of Audio/Visual Instruction – University of Wisconsin Extension, 1327 University Ave., Madison, WI 53706, (608) 262-1644.

Did Jenny Have To Die? Preventing Teen Suicide
Sunburst Communications
39 Washington Avenue
Pleasantville, NY 10570-9971

This story of one teen's suicide covers all the material needed to inservice staff or students. The focus is on one case that allows viewers to clearly identify the process involved in a teen taking his/her life. The incident leading to Jenny's suicide is her breakup with her boyfriend. This involves an abortion which may detract from the story's usefulness for some communities. Suitable for grades 9-12. Filmstrip, $149.00. Videocassette, $159.00. U-Matic, $179.00.

Sudden Adolescent Death – How To Prevent It
Human Relations Media
175 Tompkins Avenue
Pleasantville, NY 10570

Uses case histories to teach youth their role in preventing the suicide of their peers. Also deals with adolescent death through reckless driving, drug abuse, and violence. Filmstrip program, $108.00.

Suicide
Bureau of Audio/Visual Instruction
University of Wisconsin Extension
1327 University Avenue
Madison, WI 53706

Surveys attitudes toward suicide, theories behind it, treatment, and its effects upon family survivors. Interviews persons who have attempted suicide, members of an emergency service squad, psychologists, and family members. Discusses the loneliness and alienation that causes suicides, the general reluctance of people to deal with the problem, the guilt and blame felt by those affected by a loss. 25 minutes, color, $15.50 rental.

Teens Who Chose Life: The Suicidal Crisis
Sunburst Communications,
39 Washington Avenue
Pleasantville, NY 10570-9971

Focuses on teen suicidal behavior by telling the stories of three youths who attempt suicide but survive. Realistic presentation raises feelings of viewers which need to be sensitively dealt with through discussion. Suitable for grades 8-12. Filmstrip, $149.00. Videocassette, $159.00. U-Matic, $179.00.

Books and Booklets

Suicide of a Child
Joy and Marvin Johnson, Adina Wrobleski
Centering Corporation
Box 3367
Omaha, NE 68103-0367

An excellent booklet to provide family members after a child's suicide. Good background material for staff who must deal with survivors. $3.00.

Suicide: Questions and Answers
Adina Wrobleski
5124 Grove Street
Minneapolis, MN 55436-2481

Gives excellent facts on suicide in general. This booklet is very useful for helping professionals and other adults understand the problem. $3.25.

Suicide: The Danger Signs
Adina Wrobleski
5124 Grove Street
Minneapolis, MN 55436-2481
$3.25 per copy.

Suicide: Your Child Has Died
Adina Wrobleski
5124 Grove Street
Minneapolis, MN 55436-2481

An excellent booklet for all parents. This publication provides a positive approach to dealing with survivors. Good background information for staff who must deal with the aftermath of youth suicide. $4.95.

What about Depression?
What about Suicide?
About Self-Esteem?
Channing L. Bete Co., Inc.
200 State Road
South Deerfield, MA 01373

These three scriptographic booklets deal accurately and concisely with depression, suicide, and self-esteem. Used together, they form an excellent unit on suicide awareness and prevention. May be used at junior high and high school levels. Available in lots of 100 or more at $.90 each.

Program Materials

Adolescent Suicide Awareness Training Manual
New Jersey State Department of Education
225 West State Street
Trenton, NJ 08625

A "short course" on youth suicide and how to effect appropriate intervention. Forms an excellent basis for local program development. $13.00.

Fairfax County Public Schools: The Adolescent Suicide Prevention Program
Myra Herbert, Social Worker
Fairfax County Public Schools
Department of Student Services and Special Education
Belle Willare Administration Center
10310 Layton Hall Drive
Fairfax, VA 22030

Publication contains a brief description of the steps Fairfax County, VA, Schools took to establish a suicide prevention program. It contains many suggestions as to audiovisual resources, workshop formats, sample agendas, and discussion examples. Program description allows districts to fill in details suitable for the local community. Does not contain a comprehensive program complete with all the necessary materials. $10.00.

Prevention of Teenage Suicide: A Comprehensive, Proactive Program
Southwest Community Health Centers, Inc.
199 South Central Avenue
Columbus, OH 43223

This community-based, school-focused program contains material similar to that developed by the Cherry Creek, CO, Public Schools. Includes training materials, news releases, referral forms, and related items. $160.00.

Project Alive
Family and Children's Service of
Lancaster County
630 Janet Avenue
Lancaster, PA 17601

This audiocassette tape is a dramatization of a teenage suicide attempt. Areas covered are: warning signs, what to do, coping skills, and factors contributing to adolescent suicide. A lesson book and student handouts are included. This is suitable for stimulating discussion in a high school classroom and teaching students that help is available. $10.00.

Suicide Prevention Training Manual
Merck Sharp and Dohme
North Wales Press, Inc.
P.O. Box 1486
North Wales, PA 19454

This is a 14-lesson course to help adults deal with the facts about suicide in a manner which leads to an understanding of the suicidal person. Focuses on improving the ability to recognize a suicidal person and increasing the knowledge of what steps to take to prevent suicide attempts. Geared to suicide in general and can be used much like CPR training to train a community. $12.00.

Youth In Crisis: Seeking Solutions to Self Destructive Behavior
Sopris West
1120 Delaware Avenue
Longmont, Colorado 80501

Provides a comprehensive look at youth suicide. Includes a model approach to utilizing all community resources, including schools. $48.95.

Pamphlets

North Wales Press, Inc.
P.O. Box 1486
North Wales, PA 19454

The cost shown is for 25 copies.

Before It's Too Late: $7.50.

Suicide and How to Prevent It: $9.25.

Suicide in Youth and What You Can Do About It – A Guide for Students: $6.25.

Suicide in Young People: $7.50.

Suicide – It Doesn't Have to Happen: $7.50

Suicide in Youth and What You Can Do About It – A Guide for School Personnel: $7.50

Suicide Prevention in the Classroom: Curriculum Guide: $12.00.

Wisconsin Department of Public Instruction Resources

The Department of Public Instruction administers a broad range of programs and services to assist school districts and communities in meeting the needs of children at risk. Programs and services related to children at risk are listed in this section to encourage school and community providers to contact the persons listed for more information.

Programs and Personnel by Division

Handicapped Children and Pupil Services

Victor Contrucci
Assistant State Superintendent, (608) 266-1649

Bureau for Pupil Services

William Erpenbach, Director, (608) 266-8960

Public and Private Agency Education
Beverly Kochan, (608) 266-7118

Issues, Program Improvement Section
Linda Kunelius, Chief, (608) 266-0963

Children At Risk
Dennis Van Den Heuvel, (608) 266-1723

Child Welfare and Community Services
Suicide Prevention
William Berkan, (608) 266-7051

Alcohol and Other Drug Abuse Prevention and Intervention
Susan Fredlund, (608) 267-9242
William Richards, (608) 267-9354

Alcohol and Traffic Safety
Driver Education
Safety
I. Russell Hutter, (608) 267-9239

Pupil Services Team Section
Richard R. Roth, Chief, (608) 266-2829

School Social Work Services
School-Age Parents
Child Abuse/Assault
I. Lorraine Davis, (608) 266-7921

School Psychology Services
Leonard Pennington, (608) 266-3584

School Nursing Services
Laura Taff, (608) 266-8857

School Counseling and Guidance
Vocational Guidance
Pamela Wilson, (608) 266-9677

Bureau for Exceptional Children

Paul Halverson, Director, (608) 266-1781

Developmental, Behavioral, and Learning Impaired Section
Thomas Stockton, Chief, (608) 266-1787

Early Childhood, Sensory and Language Impaired Section
John Stadtmueller, Chief, (608) 266-6951

Program Review and Compliance Section
Nancy Holloway, Chief, (608) 266-2841

Wisconsin School for the Deaf and Hearing Impaired
John Shipman, Superintendent, (414) 728-2677

Wisconsin School for the Visually Handicapped and Visually Impaired
William English, Superintendent, (608) 755-2950

Instructional Services

John Benson
Assistant State Superintendent, (608) 266-3361

Bureau for Vocational Education

Richard Dignan, Director, (608) 267-9244

Agricultural Education
Floyd Doering, (608) 266-2207

Industrial Education
Richard Kitzmann, (608) 266-3551

Agriculture Education and FFA
Kevin Keith, (608) 267-9255

Home Economics Education and FHA-HERO
T. Elaine Staaland, (608) 266-2347

Industrial Education and VICA
John Vanderhoof, (608) 267-9251

Business Education and FBLA
Vicki Poole, (608) 267-2138
JTPA Programs
Job Training/Special Needs Programs Section
Wayne Sherry, Chief, (608) 267-9166
John Niemeier, (608) 267-9247
Patrick Sweeney, (608) 266-2158
Melinda Waggoner, (608) 267-2276

Vocational Special Needs Education
Preston Smeltzer, (608) 266-7987

Vocational/Special Education
Steven Gilles, (608) 267-9256

Community Services/Work Experience
Henry Hendricksen, (608) 267-9448

GED
Annette Weaver, (608) 267-9245

Vocational Equity
Barbara Bitters, (608) 266-9609

Office for School Improvement

Robert Gomoll, Director, (608) 266-2658

Preschool to Grade 5 Program
Thomas Diener, (608) 267-2002

Education for Employment Program
Charlotte Oinonen, (608) 266-7475

Bureau for Program Development

Arnold Chandler, Director, (608) 266-2364

Health Education
Human Growth and Development
Chet Bradley, (608) 266-7032

Consultation and Special Needs Section
Myrna Toney, Chief, (608) 266-2690

Chapter 1
Don Gehrman, (608) 267-9146
William Ernst, (608) 267-9145
Ellen Ryan, (608) 267-9142
Sue Ann Bates-Watkins, (608) 267-9141

Migrant Education
Kathleen Phillips, (608) 266-9616
David DeSoto, (608) 267-7338

Bilingual Education
Ezequiel Vargas, (608) 267-9234

Migrant Parent Involvement
Kristin Helland, (608) 267-2287

School Financial Resources and Management Services

C. Richard Nelson
Assistant State Superintendent, (608) 266-3851

Bureau for School Management Services and Federal Aids

Amza Vail, Acting Director, (608) 267-9293

Community Education Programs and Planning Services
Eric Smith, (608) 266-3569

Education Consolidation and Improvement Act of 1981, ECIA Block Grant
Maryjean Bade, (608) 266-2146

Bureau for Educational Opportunity Programs

Paul Spraggins, Jr., Director, (414) 224-4413

Ashland Office
Sally Riggs-Kessler, (715) 682-4531
Kenneth Thornton, (715) 682-4531, ext. 260

Eau Claire Office
Bonnie Dockry, (715) 836-3171

Milwaukee Southside Office
Glenda Wojtasiak, (414) 224-4296

Racine Office
Annie Jones, (414) 636-3596

Wausau Office
Jane Wiley, (715) 842-0871

Bureau for Food and Nutrition Services

Edward J. Post, Director, (608) 266-3509

Section for Nutritional Services
Kathleen Cole, Chief, (608) 266-2416

Management and Budget

Gary Johnson
Assistant State Superintendent, (608) 266-3903

Bureau for Equal Educational Opportunity

John Strother, Director, (608) 266-3275

Sex Equity
Melissa Keyes, (608) 267-9157

National Origin Equity Project
Alan Caldwell, (608) 267-2283

Liaison to American Language and Culture Education Board
Barbara Thomas, (608) 267-9232

Race Equity Project
Addie Pettaway, (608) 266-0043

Bureau for Education Information Services

Jane Lepeska, Director, (608) 266-9356

National Diffusion Network
William Ashmore, State Facilitator, (608) 267-9179

WDPI Programs Serving At-Risk Children

The Wisconsin Department of Public Instruction administers many programs and projects to serve children at risk. This section offers brief descriptions of some programs and projects which are particularly useful to school districts that are developing or administering local programs. Contact people, statutory references, and basic information are listed.

Alcohol and Other Drug Abuse Program

Section 115.36, Wis. Stats.

Contact: Susan Fredlund or William T. Richards, Consultants, Alcohol and Other Drug Abuse, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9242/ 267-9354.

The DPI provides assistance to help school districts develop AOD prevention and intervention programs. Prevention programs are designed to minimize future problems related to alcohol and other drug use, while intervention programs are designed to help students already experiencing problems. The DPI administers funds for training and for the development of model programs. School districts and CESAs may apply for grants of $10,000 to $40,000 to develop and implement an AOD prevention or intervention program. Training funds are available in the form of fellowship grants to support advanced training and education for school staff involved in the programs.

Alcohol/Driver and Traffic Safety Education

Sections 20.255(1)(hm) and 346.655, Wis. Stats.

Contact: I. Russell Hutter, Consultant, Alcohol/Driver and Traffic Safety Program, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9239.

DPI staff work with educators to develop and implement K-12 alcohol/traffic safety curriculum and instruction programs to deal with the problem of youthful drinking and driving. Curriculum materials and inservice training are provided to local school districts. Mini-grants are available to provide short-term seed money to local school districts, consortium of schools, or CESAs for support of locally initiated projects. Upon request, grant recipients must share project experiences, activities, and materials on a cost-recovery basis with other interested school districts and CESAs.

Bilingual Education

Chapter 115, Subchapter VII, Wis. Stats.

Contact: Ezequiel B. Vargas, Consultant, Bilingual/Bicultural Education, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9234.

Wisconsin state statutes define bilingual education as a "program designed to improve the comprehension and the speaking, reading, and writing ability of a limited-English speaking pupil in the English language so that the pupil will be able to perform ordinary classwork in English." The DPI provides financial and program assistance to school districts for setting up bilingual-bicultural education programs.

Community Education

Section 120.13(19), Wis. Stats.

Contact: Eric C. Smith, Consultant, Community Education and Planning, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-3569.

DPI provides program assistance to school districts to help them set up programs to reach all age groups in their communities. Some districts hire staff to coordinate use of school facilities, identify program needs, and work with school and community groups.

Early Identification Program (EIP)

Section 115.43, Wis. Stats.

Contact: Paul Spraggins, Director, Bureau of Educational Opportunity, Department of Public Instruction, 600 West Walnut, Milwaukee, WI 53212, (414) 224-4413.

EIP provides academic, personal, and career counseling to disadvantaged students (minority and low income), beginning in the eighth grade. The program, in partnership with the parents and schools, helps students make career decisions. Greatest assistance is given to students who might otherwise not be admitted to college because of poor academic performance. EIP counselors work with schools to help get students on track. This may include offering opportunities for part-time employment. Six regional offices are located around the state.

Education Consolidation and Improvement Act of 1981

Chapter 1 Migrant Education

20 U.S.C.A. ss.3801-3807 (also known as PL 97-35)

Contact: Myrna Toney, Chief, Special Needs Section, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-2690.

Through this program, DPI provides financial and program assistance to school districts serving the special needs of educationally disadvantaged migrant students.

Chapter 1 Programs

20 U.S.C.A. ss.3801-3807 (also known as PL 97-35)

Contact: Myrna Toney, Chief, Special Needs Section, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-2690.

The Education Consolidation and Improvement Act of 1981, also known as the Education Block Grant, Chapter 1, provides funds for the improvement of education and instruction in basic skills. The program is administered by the DPI and available to all Wisconsin public school districts.

Chapter 2 Programs

20 U.S.C.A. ss.3811-3863 (also known as PL 97-35)

Contact: Maryjean Bade, Consultant, Chapter 2, Bureau for School Management Services and Federal Aids, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-2146.

Federal funds, administered by DPI, provide for supplementary instructional programs for educationally disadvantaged pupils from low-income families in highly concentrated areas. School districts must have at least ten low-income students to be eligible for the funds.

Regional Offices

Ashland
c/o Northland College
Ashland, WI 54806
(715) 682-4531
Eau Claire
307 South Farwell, Room 9
Eau Claire, WI 54701
(715) 836-3171

Milwaukee North
600 West Walnut
Milwaukee, WI 53212
(414) 224-4466

Milwaukee South
931 West Madison
Milwaukee, WI 53204
(414) 224-4296

Racine
Memorial Hall
72 Seventh Street
Racine, WI 53403
(414) 636-3596

Wausau
808 North Third Avenue, Suite 203
Wausau, WI 54401
(715) 842-0871

Education for Employment

Section 115.367, Wis. Stats.

Contact: Charlotte Oinonen, Project Director, Parker Project, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-77475.

This initiative seeks to involve business, industry, and education in a partnership to develop Wisconsin's economy. An education-for-employment standard and grants for model programs emphasize providing school-supervised work experience, career exploration, employment skills and attitudes, vocational skills, academic skills, and an understanding of economics and American economic institutions.

Education for School-Age Parents

Chapter 115, Subchapter VI, Wis. Stats.

Contact: I. Lorraine Davis, Consultant, School Social Work Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-7921.

Any school board, CESA, or consortium of districts may establish a program for school-age parents and be eligible to receive state aid for 63 percent of the costs of teacher salaries, instructional aids, special transportation, and other expenses approved by the state superintendent. Programs shall be designed to provide services and instruction to meet the needs of these parents through graduation or to age 21.

Annually, prior to beginning the program, the school board submits a plan of service to the DPI. This includes the number of students expected to be served, personnel for the program, estimated salaries, and other anticipated costs.

Job Training Partnership Act (JTPA)

29 U.S.C.A. s.1533 (also known as PL 97-300 — 8 percent set aside for education coordination grants)

Contact: Wayne Sherry, Chief, JTPA/Special Needs Section, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9166.

The DPI administers the education portion of this federal program to provide education and training for youth who are at risk of failure. Programs are intended to help students develop academic and vocational skills so they can graduate from high school or achieve an equivalency diploma and be employable. DPI works with the Department of Industry, Labor, and Human Relations as well as with local businesses.

National Diffusion Network

Contact: William Ashmore, Bureau for Management Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9179.

The National Diffusion Network (NDN) seeks to promote and share locally developed educational programs that work. Through a process known as adoption, the NDN provides programs, materials, people, services, and funds to help educators all over the country find low-cost solutions to local problems. In Wisconsin, the project is administered by the DPI through its state facilitator who works directly with CESAs and local school districts to provide training and consultation. The NDN offers more than 400 exemplary programs. Content areas include basic skills, bilingual/migrant education, special education, alternative schools, gifted and talented education, and administration/organizational arrangements.

Precollege Scholarship Program

Section 115.43, Wis. Stats.

Contact: C. Richard Nelson, Assistant Superintendent, Division for School Financial Resources and Management Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-3851.

Scholarships to minority students in grades 6-12 allow them to participate in precollege classes or programs to improve academic skills in preparation for postsecondary education. Programs are held both during the school year and in the summer at Wisconsin's public and private colleges and universities.

Preschool to Grade 5 Program

Section 121.03, (P-5), Wis. Stats.

Contact: Thomas Diener, Consultant, Office for School Improvement, Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-2002.

This program provides supplemental funding to assist the Kenosha and Milwaukee school districts in developing and implementing improved educational programs for economically disadvantaged students from preschool through grade 5. DPI administers the program.

School Food Services

Contact: Edward J. Post, Director, Bureau for Food and Nutrition Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-3509.

The DPI administers the National School Lunch Program (NSLP), School Breakfast Program (SBP), Child Care Food Program (CCFP), and Summer Food Service Program (SFSP). All are supported by federal funds. Their purpose is to provide for the nutritional well-being of children, thus enabling them to concentrate on school.

The NSLP and SBP are available to public and private nonprofit schools and residential institutions. The CCFP is available to public and private nonprofit residential child care institutions and to home care providers. The SFSP is available to public and private nonprofit schools, governmental units, and residential public and private nonprofit summer camps serving children from poor economic areas.

School Nursing and Health Services

Sections 115.01(11m), 115.28(7m), 118.255, 118.29, 120.13(11)(a) and (b), 121.02(g) and (l), 140.05(16), and Chapter 143 Wis. Stats. HSS 145, Wis. Admin. Code.

Contact Person: Laura Taff, Consultant, School Nursing and Health Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-8857.

The DPI's school nursing and health services consultant works with school nurses as they provide direct acute care and health maintenance services. School nurses monitor immunization records and the administration of medications; provide health counseling for individuals and groups; identify and follow up on health problems; provide health education, program planning, and management services; and supervise health care provided by other than physicians and nurses. Priorities are given to the early identification and follow-up for health-related problems that affect pupil's ability to benefit fully from the school experience.

Vocational Opportunities Program

20 U.S.C.A. ss.2331-2334 (also known as PL 98-524)

Contact: Richard Dignan, Director, Bureau for Vocational Education, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 267-9244.

The federal Vocational Opportunities Program of the Carl Perkins Vocational Education Act provides programs to meet the special needs of handicapped individuals, disadvantaged students, single parents, and others in need of training or retraining. The DPI awards grants to school districts, CESAs, universities, and other postsecondary institutions. Participating school districts must comply with all the federal reporting requirements and employ a local vocational education coordinator.

Wisconsin Educational Opportunity Program (WEOP) Talent Search Program

Section 115.43, Wis. Stats.

Contact: Paul Spraggins, Director, Bureau of Education Opportunity, Department of Public Instruction, 600 West Walnut, Milwaukee, WI 53212, (414) 224-4413.

Talent Search helps educationally and economically disadvantaged students continue their education. WEOP counselors seek out minority and disadvantaged students, particularly in rural and urban areas of the state, and assist them in preparing for and applying to postsecondary schools. Help is provided in obtaining financial aids.

The program is supported by Special Allowance Funds from the Wisconsin Higher Education Aids Board and serves, through local school districts, those in need of help to obtain a higher education. Six regional offices are located around the state. A list of these offices appears on pp. 93-94.

WDPI Publications Related to Children At Risk

Dealing with Child Sexual Assault and Abuse: A Resource and Planning Guide

Contact: I. Lorraine Davis, Consultant, School Social Work Services, Bureau for Pupil Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-7921.

This guide is intended for use by schools in dealing with actual and suspected sexual abuse of children, both within and outside the school setting. Policies, procedures, laws, and resources are included to assist schools with staff training and to help them take advantage of existing community resources.

Guide to Curriculum Planning in Health Education

Contact: Chet Bradley, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-7032

This guide is intended to provide a framework for school districts to use in the development of a comprehensive K-12 health instruction program. The guide reflects the current thinking and experience of Wisconsin educators and includes a philosophy, goals, objectives and sample materials which can be used by curriculum planners. The emphasis is on planning a developmental K-12 instructional program, aimed at preventing emotional, physical, and social health problems by promoting a positive lifestyle. The publication focuses on ten major content areas: accident prevention and safety, community health, consumer health, environmental health, family life education, mental and emotional health, nutrition, personal health, prevention and control of disease, and substance use and abuse.

School Counseling Programs: A Resource and Planning Guide

Contact: Pamela Wilson, Wisconsin Department of Public Instruction, Bureau for Pupil Services, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-9677

This guide emphasizes cooperative and coordinated efforts of adults involved in the lives of school children. It suggests that guidance programs which involve a variety of school staff as well as parents, community members, and business/industry personnel are able to reach more students more appropriately.

The guide focuses on three major areas of development: learning, personal/social, and career/vocational. Specific pupil competencies are listed under each major developmental area. The competencies are basic skills each person must master in order to deal effectively with daily life situations. They are listed across age and grade levels and are designed to be consistent with children's physical and intellectual capabilities at various stages.

Children At Risk: A Resource and Planning Guide

Contact: Dennis Van Den Heuvel, Consultant, Children At Risk Programs, Bureau for Pupil Services, Wisconsin Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, WI 53707, (608) 266-1723.

This guide was developed to aid school districts, community groups, business, and industry in setting up comprehensive programs to serve children at risk under s. 118.153, Wis. Stats. It includes sample programs, agency resources, laws, and reporting forms as well as an outline for building a children at risk service network.

Wisconsin Department of Health and Social Services Resources

Many services and resources that might support and enhance school district efforts to assist children at risk are available through the Wisconsin Department of Health and Social Services (DHSS) and its regional and local offices. This section presents information about many of these and includes names and telephone numbers to facilitate contacts and requests for additional information.

Division of Health

Bureau of Community Health and Prevention

Contact: Ivan Imm, Bureau Director, (608) 267-9008.

This bureau's services focus on acute and communicable disease epidemiology, environmental and chronic disease epidemiology, and family and community health promotion.

Bureau of Health Care Financing

Contacts:
Madison EPSDT staff: Randy Coloni, (608) 266-9195, or Bill Newell, (608) 266-8168.
EPSDT Hotline (collect calls): (608) 266-5825.

Wisconsin's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) provides a comprehensive range of preventive health care services to children (age 0-20 years) of Medicaid-eligible families. These include all Aid to Families with Dependent Children (AFDC) and AFDC foster care families, Supplemental Security Income (SSI) children, and children who are classified eligible as *medically needy*. EPSDT services are available free of charge to children *upon request*, whether the child is under a Health Maintenance Organization/ Continuing Care Provider (HMO/CCP) or a non-HMO fee-for-service health provider system.

A key purpose of EPSDT is educating recipients to the valuable benefits received through periodic health assessments and preventive services. The Department of Health and Social Services encourages Medicaid families to utilize EPSDT services through the BHCF's EPSDT Central Notification system and through County Departments of Social Services, which together distribute information to all newly certified and recertified recipients and to those recipients who have not made use of EPSDT in the past 12 months.

Division of Community Services

Bureau of Community Programs

Contacts:
Phillip McCullough, Bureau Director, (608) 266-3719.
Elaine Carpenter, Director, Office of Mental Health, (608) 266-3249.
Larry Munson, Director, Office of Alcohol and Other Drug Abuse, (608) 266-3442.
Kary Nyre, Director, Office of Developmental Disabilities, (608) 266-2862.

The bureau offers disability programs for alcoholics and other drug abusers, the blind and vision impaired, developmentally impaired, hearing impaired, mentally disabled, and physically disabled and provides program certification for community programs.

Bureau of Economic Assistance

Contact: John Erickson, Bureau Director, (608) 266-3035.

Policies and procedures are established for AFDC payments, food stamp allocations, emergency assistance, MA eligibility, program compliance and quality control, relief to needy Indian persons, and state supplemental programs to SSI.

Bureau of Human Services

Contact:

Severa Austin, Bureau Director,
(608) 266-3443.
Michael Becker, Director, Office for
Children, Youth and Families,
(608) 266-6946.

Social services programs and the opportunity work program and budget are provided for the aged; children, youth, and families; economically disadvantaged; and Hispanic/migrants/Cuban/Hiatians.

Regional Offices

Contact: Consult the list of regional offices that follows on page 100 for specific names and addresses.

The DHSS regions assume delegated authority to make decisions about county program and administrative issues and provide leadership to implement the department's program and management initiatives.

The regional offices supervise the implementation and maintenance of state policies and procedures for community agencies (51.42/.437 boards, IM units, county human services departments, county social service departments, child support enforcement agencies, and tribal governments) and provide consultation to local service agencies to improve services to the hearing impaired, visually impaired, and physically disabled and to coordinate and advocate for services to these groups. The offices also supervise special needs and independent adoption services and pre-adoptive placement as required by the court; the Interstate Compact on Placement of Children; the independent child abuse investigatory function, including complaint investigation and monitoring for continued compliance with state statutes and state administrative codes; and the licensing and/or certification of group homes for children, day care centers, shelter care facilities for children, community-based residential facilities, and mental hygiene programs throughout the region.

The six regional offices are located in Brookfield (serving 6 southeastern counties), Milwaukee (serving Milwaukee County), Green Bay (serving 17 eastern counties), Madison (serving 12 southern counties), Eau Claire (serving 19 western counties), and Rhinelander (serving 17 northern counties).

DHSS Regional Offices

Eastern Regional Office
Lewis McCauley, Regional Director
200 North Jefferson
Suite 411
Green Bay, WI 54301-5191
(414) 436-3043

Direct Services/Regulation Chief
Robert Wagner, (414) 436-4423

Fond du Lac District Office Licensing Staff
Pat Kremer, (414) 929-3017
Virginia Evans, (414) 929-3007

Milwaukee Regional Office
Silvia Jackson, Regional Director
Sixth Floor
819 North Sixth Street
Milwaukee, WI 53203
(414) 224-4563

Direct Services/Regulation Chief (Acting)
Cliff McCoy, (414) 224-4509

Northern Regional Office
Barbara Voltz, Regional Director
1853 North Stevens Street
P.O. Box 697
Rhinelander, WI 54501
(715) 362-7800

Direct Services/Regulation Chief
Orris Bartholomew, (715) 362-7800

Wisconsin Rapids District Office Licensing Staff
Dick Cywinski, (715) 423-4305

Ashland District Office Licensing Staff
Joe Nemec, (715) 682-3404

Southeastern Regional Office
Charles Holton, Regional Director
141 Northwest Barstow Street
Room 209
P.O. Box 1258
Waukesha, WI 53187-1258
(414) 521-5098

Direct Services/Regulation Chief
Gary Kirst, (414) 521-5085

Southern Regional Office
Mary Southwick, Regional Director
3601 Memorial Drive
Madison, WI 53704
(608) 249-0441

Direct Services/Regulation Chief
Ernest Johnson, (608) 249-0441

Western Regional Office
Marge Kelly, Regional Director
718 West Clairemont Avenue
P.O. Box 228
Eau Claire, WI 54701
(715) 836-2157

Direct Services/Regulation Chief
Russell Johnson, (715) 836-2634

Regulation Supervisor
Beth Furay, (715) 836-4278

La Crosse District Office Licensing Staff
Paul Gettleman, (608) 785-9460

County Department of Social Services and Human Services Agencies

Adams County Department of Health and Social Services
Richard Holt, Director
149 North Main Street, Box 601
Adams, WI 53910
(608) 339-3356

Ashland County Department of Social Services
Sherman Secord, Director
Courthouse, Room 101
Ashland, WI 54806
(715) 682-7004

Barron County Department of Social Services
Shirley H. McGiffin, Director
Courthouse, Room 338
Barron, WI 54812
(715) 537-5691

Bayfield County Department of Social Services
Cheryl Huenink, Director
Courthouse, Box 308
Washburn, WI 54891
(715) 373-2277

Brown County Department of Social Services
William Miller, Director
300 South Adams Street
Green Bay, WI 54301
(414) 436-7011

Buffalo County Department of Social Services
Jerome W. Benson, Director
Courthouse Annex
Alma, WI 54610
(608) 685-4412

Burnett County Department of Social Services
Thomas E. Keith, Director
County Government Center, Box 300-130
Siren, WI 54872
(715) 349-2131

Calumet County Department of Human Services
Norman E. Brickl, Director
Courthouse, 206 Court Street
Chilton, WI 53014
(414) 849-2361

Chippewa County Department of Social Services
John D. Thurman, Director
2833 County Trunk I
Chippewa Falls, WI 54729
(715) 723-2285

Clark County Department of Social Services
Brian Bushnell, Director
Courthouse, Box 190
Neillsville, WI 54456
(715) 743-4621

Columbia County Department of Social Services
Robert W. Andrews, Director
711 East Cook Street, Box 134
Portage, WI 53901
(608) 742-9227

Crawford County Human Services Department
Kenneth L. Arneson, Director
111 West Dunn Street
Prairie du Chien, WI 53821
(608) 326-6431, ext. 244

Dane County Department of Social Services
Jerry McCartney, Director
1202 Northport Drive
Madison, WI 53704
(608) 249-5351

Dodge County Department of Social Services
Donald W. Noltner, Director
Dodge County Courthouse
Juneau, WI 53039
(414) 386-2777

Door County Department of Social Services
Ron Richart, Director
Courthouse, Box 67
Sturgeon Bay, WI 54235
(414) 743-5511

Douglas County Department of Social Services
Gerald Egan, Director
Courthouse Annex
1313 Belknap Street
Superior, WI 54880
(715) 394-0304

Dunn County Department of Human Services
John M. Borup, Director
808 Main Street
Menomonie, WI 54751
(715) 232-1116

Eau Claire County Department of Human Services
Lee Johnson, Director
202 Eau Claire Street
P.O. Box 840
Eau Claire, WI 54702
(715) 833-1977

Florence County Department of Social Services
Duane A. Folz, Director
Courthouse, Box 170
Florence, WI 54121
(715) 528-3296

Fond du Lac County Department of Social Services
Marvin F. Diedrich, Director
87 Vincent Street
Fond du Lac, WI 54935
(414) 929-3438

Forest County Department of Social Services
Mary E. Barge, Director
Courthouse, Box 9
Crandon, WI 54520
(715) 478-3351

Grant County Department of Social Services
John Angeli, Director
111 South Jefferson Street
Box 111
Lancaster, WI 53813
(608) 723-2136

Green County Human Services Department
Bruce Willett, Director
Pleasant View Complex
Box 216
Monroe, WI 53566
(608) 328-9393

Green Lake County Department of Social Services
Stephen Szatkowski, Director
500 Lake Street
Green Lake, WI 54941
(414) 294-6566

Iowa County Department of Social Services
Michael J. Tiber, Director
109 West Fountain Street, Box 98
Dodgeville, WI 53533
(608) 935-9311

Iron County Department of Social Services
Lawrence Samardich, Director
Courthouse, 300 Taconite Street
Hurley, WI 54534
(715) 561-3636

Jackson County Department of Social Services
Marshall H. Graff, Director
221 Main Street
P.O. Box 457
Black River Falls, WI 54615
(715) 284-4301

Jefferson County Human Services Department
Mark Quam, Director
N 3995 Annex Road
Jefferson, WI 53549
(414) 674-3105

Juneau County Department of Social Services
Patrick Liston, Director
Courthouse Annex
220 East La Crosse Street
Mauston, WI 53948
(608) 847-6262

Kenosha County Department of Social Services
N. Clark Earl, Director
714 52nd Street
Kenosha, WI 53140
(414) 656-6500

Kewaunee County Department of Social Services
Giles J. Hanson, Director
510 Kilbourn Street
Kewaunee, WI 54216
(414) 388-3777

La Crosse County Department of Human Services
Paul R. Zei, Director
1707 Main Street
P.O. Box 4002
La Crosse, WI 54601
(608) 784-8900

Lafayette County Department of Social Services
Michael T. Schafer, Director
700 North Main Street, Box 206
Darlington, WI 53530
(608) 776-4066

Langlade County Department of Social Services
Jim Meisinger, Director
1225 Langlade Road
Antigo, WI 54409
(715) 627-6258

Lincoln County Department of Social Services
Curtis Moe, Director
Menard Center
503 South Center Avenue, Box 547
Merrill, WI 54452
(715) 536-0300

Manitowoc County Department of Social Services
Thomas Stanton, Director
926 South 8th Street
P.O. Box 3007
Manitowoc, WI 54220
(414) 683-4230

Marathon County Department of Social Services
Richard W. Delap, Director
400 East Thomas Street
Wausau, WI 54401
(715) 848-1381

Marinette County Department of Social Services
John Gustafson, Director
1939 Hall Avenue, Box 46
Marinette, WI 54143
(715) 732-0191

Marquette County Department of Social Services
Kenneth Ramminger, Director
77 Park Street, Box 405
Montello, WI 53949
(414) 297-9135

Menominee County Department of Human Services
Thomas Bentz, Director
Box 280
Keshena, WI 54135
(715) 799-3861

Milwaukee County Department of Social Services
Thomas A. Brophy, Director
235 West Galena
Milwaukee, WI 53205
(414) 289-6200

Monroe County Human Services Department
Donald E. Mulry, Director
Community Services Building
Route 2, County Trunk B
Sparta, WI 54656
(608) 269-8600

Oconto County Department of Social Services
Lyle Dakins, Director
Courthouse, 300 Washington Street
Oconto, WI 54153
(414) 834-3865/834-3868

Oneida County Department of Social Services
Paul E. Spencer, Jr., Director
Courthouse, Box 400
Rhinelander, WI 54501
(715) 362-5695

Outagamie County Department of Social Services
James E. Stampp, Director
410 South Walnut Street
Appleton, WI 54911
(414) 735-5177

Ozaukee County Department of Social Services
Larry Neve, Director
Courthouse Building, Room 402
Port Washington, WI 53074
(414) 284-9411

Pepin County Department of Human Services
Richard Sundbo, Director
550 Seventh Avenue West, Box 69
Durand, WI 54736
(715) 672-8941

Pierce County Department of Human Services
Dale C. Melstrom, Director
124 North Oak Street
P.O. Box 670
Ellsworth, WI 54011
(715) 273-3531

Polk County Department of Social Services
Richard L. Kammerud, Director
Municipal Building, Box 216
Balsam Lake, WI 54810
(715) 485-3133

Portage County Community Human Services Department
Judy A. Bablitch, Director
817 Whiting Avenue
Stevens Point, WI 54481
(715) 345-5350

Price County Social Services Department
John A. Chrest, Director
Courthouse
Phillips, WI 54555
(715) 339-2158

Racine County Department of Human Services
William Adams, Director
207 Seventh Street
Racine, WI 53403
(414) 636-3671

Richland County Department of Social Services
Lewis Koehn, Director
250 South Main, P.O. Box 673
Richland Center, WI 53581
(608) 647-8821

Rock County Department of Social Services
Ursula S. Myers, Director
Highway 51, North
Box 1649
Janesville, WI 53547-1649
(608) 756-5255

Rusk County Department of Social Services
Thomas Lovely, Director
Courthouse, 311 Miner Avenue
Ladysmith, WI 54848
(715) 532-2116

Sauk County Department of Social Services
Wesley M. Rohrer, Director
116 5th Avenue, Box 21
Baraboo, WI 53913
(608) 356-4866

Sawyer County Department of Social Services
Patricia K. Acheson, Director
Courthouse, Box 192
Hayward, WI 54843
(715) 634-4806

Shawano County Department of Social Services
Earl G. Lundmark, Director
Courthouse, 311 North Main Street
Shawano, WI 54166
(715) 526-6178

Sheboygan County Department of Social Services
John E. Lubbers, Director
1427 North Tenth Street
Sheboygan, WI 53081
(414) 459-3200

St. Croix County Department of Social Services
Robert H. Sanden, Director
904 Third Street
Hudson, WI 54016
(715) 386-5581

Taylor County Community Human Services Department
Tom Pink, Director
219 South Wisconsin Avenue
Medford, WI 54451
(715) 748-3332

Trempealeau County Department of Social Services
DuWayne A. Mickelson, Director
Courthouse, 1720 Main
Box 67
Whitehall, WI 54773
(715) 538-2311

Vernon County Department of Social Services
Richard Q. Scott, Director
Route 3, Box 823
Viroqua, WI 54665-0823
(608) 637-2135

Vilas County Department of Social Services
Edward J. Leveille, Director
Courthouse, Box 369
Eagle River, WI 54521
(715) 479-3668

Walworth County Department of Social Services
Brian Wexler, Director
County Road NN, Box 1006
Elkhorn, WI 53121
(414) 741-3300

Washburn County Department of Social Services
Dennis L. Boland, Director
210 West Fourth Avenue
P.O. Box 250
Shell Lake, WI 54871
(715) 468-7878

Washington County Department of Social Services
Donald Ryd, Director
320 South Fifth Avenue
West Bend, WI 53095
(414) 338-4610

Waukesha County Department of Social Services
Peter W. Schuler, Director
500 Riverview Drive
Waukesha, WI 53186
(414) 548-7212

Waupaca County Department of Social Services
Dennis D. Wendt, Director
1402 Royalton Street, Box 72
Waupaca, WI 54981
(715) 258-8502

Waushara County Department of Social Services
August K. Pagel, Director
Courthouse, Box 898
Wautoma, WI 54982
(414) 787-3303

Winnebago County Department of Social Services
Norman L. Whitford, Director
448 Algoma Boulevard
Box 2646
Oshkosh, WI 54903
(414) 233-1300, ext. 301

Wood County Department of Social Services
Phillip J. Lukowicz, Director
Courthouse
400 Market Street
Wisconsin Rapids, WI 54494
(715) 421-1010

Division of Corrections

Bureau of Juvenile Services

Contact: John Ross, Bureau Director, (608) 266-7551.

The Division of Corrections operates Ethan Allen School, Lincoln Hills School, and the Youth Aids Aftercare Supervision.

Division of Care and Treatment Facilities

Genetic Counseling Provided by Central Wisconsin Center

Contact: Richard Scheerenberger, Director, Central Wisconsin Center, 317 Knutson Drive, Madison, WI 53704, (608) 249-2151.

Community Services System

Contact: Consult the list of community services boards following this section for specific names and addresses, or call the Community Services Division, Wisconsin Department of Health and Social Services, (608) 266-3444 or 266-2754.

A Community Services Board develops and budgets for a comprehensive program ensuring continuous care for the mentally ill, mentally retarded, and alcohol and drug abusers in the local community. A board must provide the following services: prevention, diagnosis, evaluation, inpatient, outpatient, residential care, partial hospitalization, precare, aftercare, emergency care, rehabilitation, supportive transitional care, professional consultation, public information and education, related research, and inservice training. Boards provide these services or contract them from private, voluntary, and public agencies.

Under state legislation, when funds are available, they are allocated to a county based on its population. Programs are reviewed by county boards of supervisors and the regional Health Systems Agency. Final approval and allocation are made after review by the Department of Health and Social Services.

Section 51.42, Wis. Stats., was enacted into law on January 1, 1977, due to nationwide dissatisfaction with institutionalized and custodial care. Wisconsin counties thus became responsible for providing services in alcohol and drug abuse, developmental disabilities, and mental health. The legislation requires this to be done through community boards or boards appointed by a county board of supervisors.

Counties may form a 51.42/.437 board to provide all mental disability services, or they may form two separate boards (a Unified Services Board [s.51.42 board] for mental health and alcohol and drug abuse services and a Developmental Disabilities Services Board [s.54.437 board] for developmental disabilities only). A third option is to form a community human services board under 2.46.23 in place of the s.51.42 board or s.51.437 board.

Directory of Community Services Boards

Adams County Unified Board
Cynthia A. Griffin, Director
P.O. Box 295
320 West Lake Street
Friendship, WI 53934
(608) 339-7881

Bayfield County Unified Services Board
Eric Fredenberg, Director
Courthouse, Box 276
Washburn, WI 54891
(715) 373-2212

Brown County Unified Board
William C. Daumueller, Director
2900 St. Anthony Drive
Green Bay, WI 54301
(414) 468-1136

Buffalo County Department of Human Services
Jerome W. Benson, Director
Courthouse Annex, Box 600
Alma, WI 54610
(608) 685-4412

Calumet County Department of Human Services
Norman E. Brickl, Director
206 Court Street
Courthouse
Chilton, WI 53014
(414) 849-2361

Chippewa County Unified Services Board
C. W. King, Director
2829 County Trunk I
Chippewa Falls, WI 54729
(715) 723-0344

Clark County Community Services Board
Arlyn Mills, Director
Courthouse, Room 507
Neillsville, WI 54456
(715) 743-3241

Columbia County Comprehensive Service Board
Michael Schroeder, Director
711 East Cook Street, Box 122
Portage, WI 53901
(608) 742-9202

Crawford County Human Services Department
Kenneth L. Arneson, Director
111 West Dunn Street
Prairie du Chien, WI 53821
(608) 326-6431, ext. 244

Dane County Unified Services Board
Paul Meyer, Director
1206 Northport Drive
Madison, WI 53704
(608) 246-2980

Dodge County Unified Services Board
Terrence B. Dalton, Director
199 Home Road
Juneau, WI 53039
(414) 386-2411

Door County Unified Board
Ted Bauch, Director
1715 Rhode Island
Sturgeon Bay, WI 54235
(414) 743-7216

Douglas County Comprehensive Planning Board
Julie Peters, Director
1313 Belknap Street, Room 200
Superior, WI 54880
(715) 394-0387

Dunn County Department of Human Services
John M. Borup, Director
808 Main Street
Menomonie, WI 54751
(715) 232-1116

Eau Claire County Department of Human Services
Lee Johnson, Director
202 Eau Claire
Box 840
Eau Claire, WI 54702-3650
(715) 833-1977

Florence County Combined Services Board
Duane A. Folz, Director
Courthouse, Box 170
Florence, WI 54121
(715) 528-3296

Fond du Lac County Unified Board
Randolph Kreul, Jr., Director
459 East First Street
Fond du Lac, WI 54935
(414) 929-3571

Green County Human Services Department
Bruce Willett, Director
Pleasant View Annex
Monroe, WI 53566
(608) 328-9393

Green Lake County Community Unified Board
Linda Vanness, Director
500 Lake Street
Green Lake, WI 54941
(414) 294-6568

Human Service Board of Langlade/Lincoln/Marquette Counties
Peter DeSantis, Director
1100 Lakeview Drive
Wausau, WI 54401
(715) 842-1636

Human Service Center of Forest/Oneida/Vilas Counties
Donald Cannady, Director
705 East Timber Drive
P.O. Box 897
Rhinelander, WI 54501-0897
(715) 369-2215

Jackson County Department of Human Services
Marshall H. Gratt, Director
221 Main Street
Box 457
Black River Falls, WI 54615
(715) 284-4301

Jefferson County Human Services Department
Mark Quam, Director
N 3995 Annex Road
Jefferson, WI 53549
(414) 674-3105

Kenosha County Comprehensive Board
Roger Andreoli, Director
714 52nd Street
Kenosha, WI 53140
(414) 656-6788

Kewaunee County Unified Board
John E. Schad, Director
522 4th Street
Algoma, WI 54201
(414) 487-5231

La Crosse County Department of Human Services
Paul R. Zei, Director
1707 Main Street
P.O. Box 4002
La Crosse, WI 54601
(608) 784-8900

Lafayette County Unified Services
Steven L. Barber, Director
312 Washington Street
Darlington, WI 53530
(608) 776-4006

Lincoln County Developmental Disabilities Services Board
Terry Schmidt, Director
912 Memorial Drive
Merrill, WI 54452
(715) 536-0350

Manitowoc County Community Board
Thomas G. Kuckkahn, Director
4204 Calumet Avenue
Manitowoc, WI 54220
(414) 683-4380

Marinette County Unified Services Board
Joseph N. Heller, Director
Mission Point Building
400 Wells Street
Marinette, WI 54143
(715) 732-4455

Marquette County Unified Services Board
Amelia Wolvin, Director
77 West Park Street
P.O. Box 274
Montello, WI 53949
(608) 297-9151

Menominee County Department of Human Services
Thomas Bentz, Director
P.O. Box 280
Keshena, WI 54135
(715) 799-3861

Milwaukee County Combined Community Services Board
James Wahner, Director
235 West Galena
Milwaukee, WI 53226
(414) 257-7500

Monroe County Department of Human Services
Donald E. Mulry, Director
Community Services Building
Route 2, County Trunk B
Sparta, WI 54656
(608) 269-8600

Northern Pines Unified Services Board
James D. Ahasay, Director
1065 West Seventh Avenue
Box 518
Cumberland, WI 54829
(715) 822-4747

Oconto County Unified Health Services
Dennis Tomchek, Director
835 South Main
Oconto Falls, WI 54154
(414) 846-8114

Outagamie County Community Board
John R. Maurice, Director
3365 West Brewster Street
Appleton, WI 54914
(414) 735-5270

Ozaukee County Comprehensive Services Board
Fred Hesselbein, Director
121 West Main Street
P.O. Box 307
Port Washington, WI 53074
(414) 284-9411

Pepin County Department of Human Services
Richard Sundbo, Director
550 Seventh Avenue West
Box 69
Durand, WI 54736
(715) 672-8941

Pierce County Department of Human Services
Dale C. Melstrom, Director
414 West Main Street
P.O. Box 670
Ellsworth, WI 54011
(715) 273-3531

Portage County Department of Human Services
Judy Bablitch, Director
817 Whiting Avenue
Stevens Point, WI 54481
(715) 345-5350

Racine County Department of Human Services
Bill Adams, Director
207 Seventh Street
Racine, WI 53403
(414) 636-3671

Rock County Developmental Disabilities Board
Dale Thompson, Director
Health Care Center Complex
P.O. Box 1867
Janesville, WI 53545
(608) 755-2650

Rock County 51.42 Board
Dennis Kirchoff, Director
P.O. Box 351
Janesville, WI 53547
(608) 755-2500

Sawyer County Comprehensive Planning Board
Jerry St. Catherine, Director
315 West Fifth Street
P.O. Box 729
Hayward, WI 54843
(715) 634-4751

Sheboygan County Unified Board
Robert J. Matzek, Director
615 North Sixth Street, Courthouse
Sheboygan, WI 53081
(414) 459-3056

St. Croix County Unified Services Board
Gary D. Johnson, Director
Route 2, Box 33A
New Richmond, WI 54017
(715) 246-6991

Taylor County Department of Human Services
Tom Pink, Director
219 South Wisconsin Avenue
Medford, WI 54451
(715) 748-3332

Trempealeau County Unified Board
Dianne Nelson, Director
1720 Main Street, Courthouse
P.O. Box 67
Whitehall, WI 54773
(715) 538-2311

Tri-County Human Services Center
H. Pearce Konold, Director
425 Sixth Street
P.O. Box 398
Reedsburg, WI 53959-0398
(608) 524-4391

Unified Board of Grant and Iowa Counties
Peter Pfotenhauer, Director
250 North Court
Platteville, WI 53818
(608) 348-8455

Unified Health Services of Shawano/Waupaca Counties
Charles Hillman, Director
10 Tenth Street
Box 119
Clintonville, WI 54929
(715) 823-6531

Unified Services Board of Ashland/Iron/Price Counties
Ronald Lockwood, Director
206 Sixth Avenue West, Room 210
Ashland, WI 54806
(715) 682-8177

Vernon County Unified Board
Dave Sierer, Director
Route 3, Box 168
Viroqua, WI 54665
(608) 637-3187

Walworth County Developmental Disabilities Board
William J. Truesdale, Director
Box 88
Elkhorn, WI 53121
(414) 741-4118

Walworth County Unified Board
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Suicide Prevention Legislation

The following excerpts from Wisconsin statutes are provided in an effort to assist interpretation of statutes pertaining to suicide prevention. Please note that the statutes are not reprinted in their entirety.

15.377(7) COUNCIL ON SUICIDE PREVENTION. There is created a council on suicide prevention in the department of public instruction. The council shall consist of 2 persons appointed by the state superintendent of public instruction, at least one of whom is not an employe of the department of public instruction, 2 persons appointed by the secretary of health and social services, at least one of whom is not an employe of the department of health and social services, one person and one physician appointed jointly by the state superintendent of public instruction and the secretary of health and social services and one member of the council on criminal justice appointed by the chairperson of that council. Members shall be appointed for terms expiring on July 1, 1989.

20.255(2)(fs) *Aid for suicide prevention programs.* The amounts in the schedule for a payment of $3,000 annually to each cooperative educational service agency to provide assistance to school districts for suicide prevention programs.

115.365 Assistance to schools for suicide prevention programs. **(1)** The purpose of this section is to enable and encourage public and private schools to develop programs designed to prevent suicide among minors.

(2) The department, in conjunction with the department of health and social services, shall:

(a) Develop and conduct training programs in suicide prevention for the professional staff of public and private schools, county departments under ss. 46.215, 46.22 and 51.42. The programs shall include information on how to assist minors in the positive emotional development which will help prevent suicidal tendencies; the detection, by minors, school staff and parents, of conditions which indicate suicidal tendencies; the proper action to take when there is reason to believe that a minor has suicidal tendencies or is contemplating suicide; and the coordination of school suicide prevention programs and activities with the suicide prevention and intervention programs and activities of other state and local agencies. Persons other than the professional staff of public and private schools, county departments under ss. 46.215, 46.22 and 51.42 may attend the training programs. The department may charge such persons a fee sufficient to cover the increased costs to the department of their participation in the programs.

(b) Provide consultation and technical assistance to public and private schools for the development and implementation of suicide prevention programs and the coordination of those programs with the suicide prevention and intervention programs of other state and local agencies.

118.01(2)(d)7. The skills needed to make sound decisions, knowledge of the conditions which may cause and the signs of suicidal tendencies, knowledge of the relationship between youth suicide and the use of alcohol and controlled substances under ch. 161 and knowledge of the available community youth suicide prevention and intervention services. Instruction shall be designed to help prevent suicides by pupils by promoting the positive emotional development of pupils.

118.295 Suicide intervention; civil liability exemption. Any school board, private school, county handicapped children's education board or cooperative educational service agency, and any officer, employe or volunteer thereof, who in good faith attempts to prevent suicide by a pupil is immune from civil liability for his or her acts or omissions in respect to the suicide or attempted suicide. The civil liability immunity provided in this section is in addition to and not in lieu of that provided under s. 895.48.

Editor's note: 1985 Act 29 provides that ss. 15.377(7) and 20.255(2)(fs), listed on the previous page, are repealed on July 1, 1989. 1985 Act 29 also provides that s. 118.01(2)(d)7 takes effect July 1, 1988.

The excerpt of s. 115.365(2)(a) includes the amendments contained in 1985 Act 176, which went into effect April 10, 1986.

Appendix I

Suicide Prevention Bibliography

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